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S. HRG. 103-562

CHILDREN'S NEEDS UNDER HEALTH CARE REFORM

Y 4. F 49: S. HRG. 103-562

Children's Needs Under Health Care...

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

NOVEMBER 30, 1993

DEPOSITORY

JUL 2 1 1994

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
78-827—CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044430-6

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CHILDREN'S NEEDS UNDER HEALTH CARE REFORM

TUESDAY, NOVEMBER 30, 1993

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senator Danforth.

[The press release announcing the hearing follows:]

[Press Release No. H–48, November 29, 1993]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON CHILD HEALTH ISSUES UNDER HEALTH CARE REFORM

WASHINGTON, DC—Senator Donald W. Riegle (D–MI), Chairman of the Committee on Finance Subcommittee on Health for Families and the Uninsured, announced today that the Subcommittee will hold a hearing on child health issues under health care reform.

The hearing is scheduled for *10:00 A.M. on Tuesday, November 30, 1993,* and will be held in room SD–215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Riegle stated: "I am holding this hearing to examine how children are covered under the major health care reform proposals."

"Over 9 million children are uninsured; others have benefits but these are inadequate. As Congress debates health care reform, we must make sure all children have a comprehensive set of benefits that meet their health needs," Senator Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The meeting will come to order. Let me welcome all those in attendance this morning and make a special welcome, extend a special welcome to our witnesses today.

The purpose of our hearing this morning is to examine the unique needs of children that must be addressed under the health care reform effort. It is estimated that over 9 million children are uninsured in our country today, and that includes an estimated 300,000 in my home State of Michigan. Of course, we have many more that are underinsured, as that word is used.

A child's health care coverage most often depends upon their parents' employment. If a parent loses a job or changes jobs, children are at risk, of course, of losing their coverage. Children with pre-

existing health conditions who need coverage the most often are the ones who cannot get it at all.

Many other children have inadequate benefits that do not cover preventive care, which is really the most cost effective care that we are able to provide. Under any reform plan it is absolutely critical that all children are guaranteed a comprehensive set of health care benefits. And it is my own preference that children, along with expectant mothers, should be the first to be phased into the new reformed system.

Before we adjourned last week 31 Senators, including me, introduced the President's health care reform plan called "The Health Security Act." Several members of the Finance Committee here—Senator Chafee, Senators Breaux and Durenberger—have introduced alternate plans. We will all be working together to iron out the differences that exist as we shape and put together the best possible health care reform program for the country.

I very much look forward to hearing from our witnesses this morning about how the major plans that have been introduced, in fact, propose to meet children's needs and where they would also fall short.

Children will not automatically be protected by reform. So I think it is very important that we not let children's issues get lost in the shuffle of the larger debate over health care reform.

So I think our hearing this morning is a very important start to understanding the particular needs that children face, so that we can make sure that they are addressed properly.

I want to say, too, that Chairman Moynihan has a very deep interest in how health reform affects everyone in the society, but very particularly children. This has been an issue of interest to him over many years in terms of what is happening with children and youngsters in our society. So I know he will take great interest in this hearing record this morning.

Our first witness this morning will be Dr. Judith Feder. I want to say at the outset how much I appreciate as a citizen, and as a member of this Committee, and as a member of the Senate, the tremendous effort and leadership effort that you have made personally in working and developing the President's health care proposal, being really at the very center of that team from the beginning, and now serving as the principal Deputy Assistant Secretary of Planning and Evaluation at the Department of Health and Human Services.

I have served under seven Presidents here now and we have had six previous Presidents that have had a lot to do, but they have not managed to get to the health care reform issue. Just as a personal note, I went to see President Bush when he was in that office and as he and I had come to the Congress together back in 1966—in fact, we both had been in the same party at that time. I changed my party affiliation back in 1973.

I appealed to the President at that time to take up the health care issue and gave him what I thought were compelling arguments for doing so. That administration had a different focus at that time and they really didn't get around to tackling this issue.

It is an enormously complex question, a difficult question, to work through from start to finish. I think it is greatly to the credit

of the President and the First Lady that they have made this a principal operating priority of the administration and have undertaken to do the serious policy work that is required here to sort it out and figure out how we adjust the system to get the pluses and avoid the minuses.

In doing that, I have been privileged to be present at a number of meetings over many months and to watch you participate. I want to say again how much I personally appreciate your individual leadership and the fact that at every turn I think you have given not only very good advice, but I think the kind of effort and energy that the country has needed for a long, long time.

I sometimes think that it may have been the need to harness more of the talent of women in this country to really get at the health care issue. But clearly, we have seen I think a major difference in that area as well as this new administration has come to town. It is all to the good.

So I am very pleased with what you have been able to bring to this effort. I am very interested in what you are going to tell us today about how children are dealt with under the health care reform proposal and any suggestions you have for us as we move into this area.

So with that, let me welcome you and invite your statement now.

STATEMENT OF JUDITH FEDER, PH.D., PRINCIPAL DEPUTY ASSISTANT SECRETARY, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. FEDER. Thank you very much, Mr. Chairman. It is indeed an honor to be representing an administration that as you have indicated has finally taken the lead as the President should in health care reform and we very much look forward to working with you and building upon your long efforts in this area to achieve what the goal to which we are all committed, which is universal coverage for all Americans and especially our Nation's kids.

I would appreciate your including my longer statement in the record and I will make some briefer remarks.

Senator RIEGLE. Without objection, so ordered.

[The prepared statement of Dr. Feder appears in the appendix.]

Dr. FEDER. I come before you today to talk about an unprecedented opportunity to meet the challenges of our Nation and in particular the future of our Nation through our children.

The Children's Defense Fund 1992 Report, "The State of America's Children," provides some vivid illustrations about the enormous challenges we and our children face every day. Every year nearly 1 million infants start life at a disadvantage because their mothers did not receive early prenatal care.

More than 250,000 babies are born at low birth weight, needing advanced medical technology to survive, and often still are left vulnerable to a life time of disabilities.

Studies of several American cities suggests that fewer than half the infants and toddlers in many urban areas are immunized fully. Millions of American children have no health insurance and tens of millions of Americans live in communities where they have little access to doctors, hospitals or health clinics.

These statistics should tell us how serious the problem is, but we often understand problems better when we see them as human events faced by individual families.

Diana and Melvin Seger of Grand Rapids, MI know too well the pains of our current system. Mrs. Seger did not have health insurance when she was pregnant and could not afford to go to either of the two hospitals within 20 minutes drive from their home for the delivery of their third child, David.

Instead, they chose a more affordable hospital an hour-and-a-half away, but were unable to reach that hospital when Mrs. Seger went into labor shortly after leaving home. The couple ended up at an Indian health service outpatient clinic unequipped to handle deliveries. The baby was deprived of oxygen and as a result was severely brain damaged. David spent much of his first 3 years of life in and out of hospitals and subsequently died.

This family's experience reveals to us the pain that comes with a lack of insurance that leads to a lack of care.

Another family story illustrates the financial burden of getting care in our system today, even when that care is provided. Ricky and Sandy Recklett from Waldorf, MD had a child, Jeffrey, who was born with a brain stem defect. The baby was fine during the day, but stopped breathing when he was asleep.

For years the baby had to have special equipment to monitor his breathing at night. Although their insurance covered this service initially, the policy had a life time limit. That threshold was exhausted in the early years of Jeffrey's illness.

Jeffrey is now fine, has a pacemaker, and is a star athlete, but the family is $600,000 in debt and facing bankruptcy.

Mr. Chairman, we all agree that the nation must address these problems and help families like those I just described. The Health Security Act represents a giant step forward for our children because it guarantees that all children will have access to comprehensive health care coverage, including prenatal services for their mothers.

The Act provides a benefits package which will include a comprehensive set of health services and which prohibits plans from excluding children or anyone due to pre-existing conditions.

Prevention is the cornerstone of the Health Security Act. The comprehensive benefits package includes a broad array of preventive services not covered by the vast majority of today's insurance plans—immunization, well baby care, and other screenings and early detection methods which will solve or prevent health problems before they become serious illnesses.

In addition, our first investment in healthy children is good prenatal care for mothers. The Health Security Act does this by providing complete prenatal care with no cost sharing. It then guarantees access to a set of appropriate preventive services throughout a child's life to ensure that each child and their family can prevent disease and can treat medical problems as they arise.

In an effort to ensure that there is no gap in service for low-income children, the plan includes a new capped Federal program addressing their needs. Services included are Medicaid services that go beyond the guarantees of the comprehensive benefit package, to cover services like hearing aids, transportation and therapies.

Low-income kids will retain the benefits they now have, including full EPSDT protection even if the benefits are not included in the guaranteed package because of this new Federal program.

Comprehensive coverage for prevention and medical treatment go a long way towards easing the pressure on all children and families in America. But families who have children with chronic health problems or severe disabilities face special challenges.

In talking with parents of children with disabilities, costly disabilities, I have met many families who have shared their experience with me. A single mom with two children with cystic fibrosis whose insurance premiums nearly double every year; the parents of a 6-year-old whose extensive need for medical supports have exhausted the life-time limits of their insurance coverage; the mother of twins born prematurely with cerebral palsy, seizure disorders and mental retardation who has no insurance at all.

All these families will be covered under the Health Security Act through the guaranteed benefit package and coverage through the health alliances that States will establish.

In addition to the benefits in the guaranteed package, the President's plan has a new long-term care program which represents a major increase over Federal spending and State spending for community health services, will provide a range of supports to people with severe disabilities regardless of their age or income at home and in their communities where it is they want to stay.

Unlike the current Medicaid Program, Federal match rates are substantial. You do not have to be poor to qualify for this program. And the program allows a tailoring of services to the needs of children and their families along with other persons with disabilities.

The new long-term care program is designed to build on State innovation and creativity in responding to the needs of people with severe disabilities and their families. The range of services that may be covered includes everything from skilled home care to occupational and physical therapy to respite care to relieve the stress that families face in caring for their loved ones.

The President recognizes that insurance alone cannot meet all the needs of our children. To ensure access to appropriate care and to help prevent disease and promote health, the Health Security Act also includes several new investment proposals, two new grant programs to support school health education programs and to help fund school health services.

New funding to help support public health initiatives of special importance to the health of children, including immunizations, lead poisoning screenings, health education and violence prevention. Additional funding will be targeted to primary care and to enabling services such as transportation and outreach services, as well as to the training of primary care doctors and other health professionals to ensure that children and expectant mothers will not lack the services they ought to have.

In conclusion, Mr. Chairman, I would point out that the Health Security Act was designed to guarantee all Americans access to comprehensive medical care. I believe that my testimony today best illustrates how the Act pursues these goals with a strong investment in the future of America through our children.

We look forward to working with you, Mr. Chairman, as we proceed with the bill and I am happy to answer any questions you might have.

Senator RIEGLE. Thank you very much. It is very important that we cover this ground and establish this record as to what it is we are endeavoring to put in place.

One of the first things that I want to start with today is the central premise of the Clinton proposal, universal coverage; and if you do not have that, then we really are missing people in society.

There are different plans on the table. I am wondering if you could give a brief sort of comparison or side-by-side analysis. You have covered the administration plan. The Chafee and the Breaux plans have also been put on the table by members of this Committee. I think it is appropriate that we look at those in contrast to the administration plan.

In the area of universal coverage, how would the Chafee and Breaux plans work insofar as you understand them?

Dr. FEDER. Well, let us look at the Breaux plan first. It has several features in common with the President's plan, particularly improving the insurance marketplace in order to improve coverage for people and to make coverage more affordable. But it does not achieve universal coverage, in large part because it does not set up mechanisms that ensure that everyone will have coverage.

A concern, as we looked in the course of our deliberations on a proposal, a concern about relying on simply market improvements to achieve universality. We looked at the experience over the last 10 to 15 years with a number of explicit programs in a variety of States that were aimed at making these kinds of changes in an effort to achieve universality.

The experience of those programs was that although improvements could be made, that simply making coverage available was insufficient without guaranteeing the affordability and ensuring the participation of all Americans.

The concern about people continuing to fall through the cracks and cost shifting from those parties to others who have insurance remains a major concern about that approach.

With respect to Senator Chafee's bill, it requires all individuals to have coverage and also makes changes in the marketplace. So in this sense it makes a stronger commitment to universality.

However, again looking at that kind of approach, an individual mandate, the concerns we have are about affordability of coverage, even for middle income Americans in the absence of an employer contribution and a concern that setting up a system that requires individuals to purchase insurance without requiring employers to participate in its costs would, in fact, undermine the coverage and protection most Americans now count on. So that is a concern we have there.

There is also a concern about whether there truly is a guarantee in that proposal of coverage for low income Americans.

Senator RIEGLE. Well, if you take the case of the family you described in Grand Rapids, having their third child and not feeling they could afford to go to the hospitals that were closer and then having that mishap, trying to get to a more distant, less expensive hospital, it seems to me that somebody in that kind of a situation

likely would not be covered under these other alternative plans as I understand and as I hear you describe them.

Dr. FEDER. Under the Breaux plan, you could not count on their being covered.

Senator RIEGLE. Right.

Dr. FEDER. Under the Chafee plan, it might depend on their income and capacity to afford it.

Senator RIEGLE. But it seems to me in recalling the story, because they had had two previous children and they obviously were sort of in an economy move, they were going further away to get cheaper care. So I almost wonder whether people in that kind of a situation would not also in a sense be routed out of the system rather than routed into it.

I mean if you do not solve the affordability problem, you do not really have a universal system, do you?

Dr. FEDER. I think that is absolutely correct.

Senator RIEGLE. Now, as I have watched the development of the administration plan, it appears to me that while it is complex, it has to be if you are going to take and capture the whole problem. I mean, you have to in effect draft a plan that collects all the problems in one overall matrix and then works them through.

Otherwise, you have this problem of cost shifting by people who are left out or cannot afford to get in. I do not see any way around that. I mean, if you are going to have universal coverage and have affordability, which are really the two things that we want to keep in tandem here, you have to find a way to in effect have sensible controls. Even if they are market-driven controls, you have got to have a system of controls that are at work here or I do not see how else you get a manageable outcome.

Dr. FEDER. I think that is absolutely right, Senator. I think that our concerns have been on the one hand to guarantee security of coverage for all Americans. That means that you have to have a mechanism that guarantees that regardless of their circumstances, whether they are working or not working or sick or well, whatever their circumstances and whatever their income, that that security is guaranteed.

And as we explored ways to achieve that, we felt that the most appropriate way to do that was to build on the financing system that we now have, which requires contributions from employers and from families based on their ability to pay.

So we feel that that is the most appropriate mechanism to ensure those guarantees. You are also raising the critical companion of universal access and that is effective cost containment. We pursue cost containment primarily through changes in the marketplace, but changes that will work effectively only if everybody is covered because we are able to create a system in which there is not cost shifting, but in which everybody participates and in which individuals and families can choose their own plan.

Senator RIEGLE. Prior to this administration coming to town, four of us here—Senator Mitchell, Senator Kennedy, Senator Rockefeller and myself—drafted a program called "Health America," which I know you are familiar with.

We had come to that very same conclusion, that unless you have a means to get to universal coverage and in effect have cost con-

tainment with it, you do not have a system that is tied together, that can really work properly.

I am also struck by the fact that there are sort of two levels of justification for doing this. One is the moral issue of facing up to human needs and helping people that need help, desperately need help, and cannot by themselves handle the problem in the health area, health emergencies and such.

But also, there is the economic issue. These health effects, they catch us one way or the other, do they not? I mean, there is no way really to avoid our health needs and not end up paying in some way or another down the line. In my experience, and the work of this committee, now over almost 40 hearings that we have had just in this subcommittee, I am struck by the fact that if we delay care or if we avoid care and needs, they eventually come back to us and usually in a more severe state and in a much higher cost.

So the economics are really inescapable, are they not? Are we not going to pay one way or the other?

Dr. FEDER. I think that is absolutely correct. And the case where I described to you where the family was unable to get appropriate delivery services led to the birth of a child with severe disabilities that not only had enormous human costs, but enormous dollar costs to the health care system.

I think what you are pointing out is that the facts are that we are paying for services now for people who do not have insurance. It is those who have insurance who pay for those who do not, even when they are working and conceivably could contribute, if their employers, like other employers, paid their fair share.

If we make that affordable to employers and to individuals, as I believe the President's plan does, it becomes a way to ensure the availability or access to services in a timely manner, particularly preventive services and primary care services to avoid the kinds of catastrophe I described.

Senator RIEGLE. This is an aside, but I think it is worth making. Today on the front of the Wall Street Journal there is a story about a crisis in public education financing in the State of Michigan, where we are in the midst of a rather radical effort to move away from the property taxes paying for much of the cost of public education and replacing that with some other form of revenue and then possibly even changing the education system itself.

What that article points out is that in the country today the difficulty that citizens have in deciding how they fit into the larger picture, in terms of paying for something like public education.

Health insurance I think falls into the same kind of circumstance where I think part of the hurdle that has to be jumped here—the President is very good at expressing views like this—is that this is one of the few things in this country that really does tie everybody together. In a society that is sort of fragmented and where there are sharper and sharper class differences and other kinds of differences that are sort of springing up and dividing people, if we can find a health care system that really helps everybody and in turn helps all of us at once, this can be one of the events that helps, I think, bring us together as a country, helps unify us as a country, on something that has a very important moral and economic foundation.

I think we may have to find new ways to express that, simply because I think unless we help the country see the greater good here, the complexity itself is such a stumbling block. I think one of the reasons why so many other administrations were scared off when they walked up to the water's edge on this problem, was that it was just too difficult—too difficult to take it apart and fix it; too difficult to explain it—and it was better to just let somebody else worry about it sometime in the future. Well, the future is here. So now we are attempting to do that.

But I think there is a basis for people to be able to deal with some of their apprehensions about the change if it can be seen in the context of the fact that we are going to be not only a healthier country, but we will end up in the end spending less rather than more. I think we have to keep our eye fixed on that or we are likely to lose our way.

Dr. FEDER. I think, Senator, I could not agree with you more. I know that your experience has paralleled my own in pursuing these issues. I think there is an enormous difference today from what there was as you and Senator Mitchell and Senator Rockefeller and others introduced your legislation earlier.

It seemed at that time when people thought about the nation's health care problems, they acknowledged that they existed, but they thought about them largely as somebody else's problem, the problem of a minority who somehow fell through the cracks in the system.

I think our experience, and I believe yours as well, is that today all Americans see this as our problem. That any one of us is at risk of losing our insurance coverage when we most need it and that we must solve it by taking care of all of us together.

Senator RIEGLE. Let me ask you this. Within the general framework of the administration's proposal, are there options open to us for trying to phase children in first?

For example, did the administration consider using Medicare—I mean, part of this comes about because of the State phase-in where the whole country is not going to be moving exactly at the same pace. But did the administration consider using Medicare to cover children as a transition to universal coverage?

Dr. FEDER. Senator, we looked at many options of phasing in children first, looked at alternative ways to do that in the course of the task force deliberations. The concern that we felt was that it was, although clearly desirable to cover children as quickly as possible, that it would be more effective if we could cover whole families.

So as we looked at phase-ins and transitions what we settled upon was a rapid phase-in, even though it is State-by-State, everyone is in by January 1, 1998; and we then have whole families covered. Consequently, we found that the most effective way to go.

Senator RIEGLE. When I think of all the little kids that I see—I have been going to the floor regularly and putting a human face on these health care crisis situations—and so many of the problems that we have encountered in Michigan with children there is really an immediate need. That is true across the country in all 50 States.

I know that the Secretary will manage a nationwide transitional risk pool for uninsured people during the phase-in period. I am

wondering if there would be any way in which we might think about trying to cover children first under that kind of a pool concept so that we do not have a child in one State with a particular problem that is afforded help that he desperately needs, and the family needs, and you have a child that is maybe 10 miles away, across the State line in the neighboring State, with the same problem and the same need that does not get the help. I mean, might we look at that as a possibility?

Dr. FEDER. I certainly think we can explore it, Mr. Chairman. I think that the concern and the reason we have established that transitional arrangement is to make certain that as the insurance system and the insurance market is changing across the nation as they adapt to new rules that people do not lose protection they now have.

And whether there are some additional measures that could be taken to enhance protection, we could certainly explore.

Senator RIEGLE. I understand your point about covering families and covering them as rapidly as we can. But given the fact there is going to be a phase-in period, I am wondering if we might direct the States or advise the States that they should try to bring children in first if they are going to have a phase-in period to try to pick up some of these needs sooner rather than later.

Dr. FEDER. Well, as we have currently structured it, when the State comes in it brings its whole system into place, which does achieve that family coverage.

Senator RIEGLE. Right.

Dr. FEDER. So there although a State coming I suppose in 1998 might gradually move toward that goal, it is contemplated that a system that changes the health insurance structure is probably most easily introduced for all citizens at one time.

As I indicated earlier, we can continue to explore that with you. But there is not contemplated a phase-in schedule for States. They are bringing their systems into place for everyone in a relatively brief period.

Senator RIEGLE. I may pursue that with you another time.

Dr. FEDER. Absolutely.

Senator RIEGLE. Let me move to the issue of children with special needs. I want to pose sort of a long question here to you and then ask you to respond to it.

As you are, I am very concerned about protecting children with special health needs under the reform package. You have discussed that in your statement. The basic benefit package is intended to restore abilities impaired "as a result of an illness or injury." Those are the quoted words.

I am pleased that the administration now has a new Federal program for those now on Medicaid to supplement the basic benefit package with benefits like respiratory care and other services that Medicaid children now have and you also described the new long-term care program in your statement.

But when I was in Michigan just a few days ago, a mother with a child with a chronic illness said that the basic package in the new wraparound program would not cover her child and that the criteria for the long-term care program targeted severely disabled children. This mother thought that the plan specifically excluded

children with birth defects, which would not then fit under this language that says as a result of injury or illness.

I am wondering if you can comment on that and is that a problem and how might we deal with it.

Dr. FEDER. Well, I think we need to go through several steps to address the concerns you have raised. First, let me be absolutely clear that all children and all persons, including those with congenital birth defects are covered under the guaranteed benefit package and that that is a vast difference from what occurs in today's insurance market based on exclusions of physician services, hospital services and other services based on pre-existing condition. So that is a guarantee that is there for everyone.

What is of concern in the cases you are describing has to do with rehabilitative or chronic care. The guaranteed package is intended to be largely a package for post-acute services or services related to an acute illness and is not designed as a chronic care benefit consistent with the nature of the insurance role.

So it is our recognition that that does not cover all the needs of children with chronic circumstances while it does provide services for all children regardless of their condition.

That is a reason that we have pursued really two other programs. As you indicated, one being the new program for low-income kids and the long-term care program, both of which address many of the needs of families with disabled kids.

However, we recognize that when it comes to long-term care services for persons with chronic conditions, which may not be—in many cases are not medical services, but are support services for some children with less severe disabilities, that we will not have fully addressed everyone's problems. But we need to start and we believe we are making a substantial and vast improvement over the current situation.

Senator RIEGLE. So then the case of a non-Medicaid child that does not meet the eligibility criteria of the new long-term program and who might need such services as respiratory care, if they have an asthmatic condition or whatever, is in a zone of types of problems that we are not necessarily solving with this package. Is that fair to say?

Dr. FEDER. I think that there are some gaps. But I guess I think we should also look at the way in which we are addressing many of those problems.

For example, in the long-term care program, although we focus on people with severe disabilities, we have explicitly included special categories for children. We will make special efforts or are in the process of continuing our efforts to refine eligibility criteria to be appropriate to children with different kinds of disabilities. So we should not look at that program as narrow, even if it does not cover everyone.

Senator RIEGLE. In raising the question, I fully appreciate the comprehensive nature of what is being addressed and what is being covered. I do not want to lose the focus on that. I think it is important for us to understand, you know, how far we are attempting to go here with this plan and where in effect it leads off so that we have clear answers for people and we understand what it is we are taking on.

And if there needs to be supplemental effort made, either in the package itself, and we will probably find areas like that with children or in other areas, or if we see some other initiative that is going to be required to the side of the health care reform package, then we can get that issue up on the radar screen and understand it and have some way of dealing with it over a period of time.

Let me ask you this finally. The administration's proposal is largely based on managed care. There are people, as you know, who are concerned that the emphasis on cost containment in managed care plans may limit, access to some types of doctors and some types of services.

I am wondering, is there evidence that would show how well children—just focusing now on kids, especially low-income children—are served by managed care plans. Do we have anything that we can look at there that helps guide us?

Dr. FEDER. Well, we are still learning from Medicaid experience in that regard. The evidence that we do have suggests that the concerns are perhaps exaggerated, that the services that Medicaid children receive under managed care plans have not proved to be less adequate than the services they are receiving under alternative arrangements.

However, when we look at that evidence, we are looking at a Medicaid experience that has not provided sufficient access to our Nation's children in an overall system in which the system is not providing adequate care.

So we recognize that as we move to a new system we need new kinds of health plans, which they really are health plans more than insurance plans, focusing on the efficient delivery of quality care rather than on the avoidance of risk.

Our plan includes mechanisms to hold those plans accountable with substantial investment in an information system and a quality improvement program so that we will be able to determine what kinds of services children, children with special needs, other population groups, are actually receiving; and so that families will be able to choose plans that are truly meeting their needs.

Senator RIEGLE. But if somebody is in a managed care system and there is a child with special needs and the bills are running up and you can see how the managed care system, whatever the goodness of its heart, may decide that this is an awfully expensive child and that they would just as soon drop the child out of the system and let the additional services and care somehow get taken care of in some other way as a managed care system. So then the logic says maybe that family wants to go into a fee-for-service plan where, you know, then they can sort of work from a menu of broader services.

I worry about what that might cost, and the affordability of that, and whether in effect that is sort of buck passing, whether the managed care system sort of says, you know, let us get rid of this family and this profile of problem and we will let somebody else worry about that or they can go into the fee-for-service system which may just be out of reach.

It is not—again, just to pose a sort of thorny hypothetical. But what I am concerned about is, if there are any appreciable number of people that fall into that category, I do not know how we pick

them up or how they get heard in the sort of mass adjustment process that is going to be going on with health care reform.

To the extent that starts to happen and you get people out there wandering around needing services for kids and not getting them, how do we find that out and loop that back into the system, so that at least, you know, they do not just become sort of a lost group?

Dr. FEDER. I think that that concern is well taken. You are talking about holding our system accountable for truly achieving the universal coverage that we are aiming for. I think that by having a system in which everyone is covered and, in fact, must be covered we have the capacity to look at and examine the adequacy of access, not only for the general population but for special groups and that is why the information system and the quality assurance system is important.

But we also need special measures to address the incentives or disincentives that you described and truly to hold plans accountable. The incentive to behave as you have described is unquestionably there in a capitated arrangement.

But if you will remember, at the same time our plans take in their money on a community-rated basis, independent of the health status of the person who enrolls, dollars are paid out to those plans on a risk-adjusted basis, a critical element of the system, to ensure that there are resources available that appropriately reflect the kinds of patients and the kinds of experience, if it is skewed, that a plan may face.

So that is one element of mitigating those incentives and ensuring appropriate care. Also, to respond in the way you described, to get rid of people, borders on or might be discrimination. We have specific provisions that protect against discrimination.

Then to deal with individual cases or individual problems, we have not only grievance procedures within plans, but all alliances must have consumer ombudsmen to be available to assist consumers and to be broadly responsive to the needs of any individual who is facing a difficulty in a plan and to ensuring the availability of service.

You spoke more broadly about needing more managed care. It would seem to me what that is contingent upon is the effectiveness of the marketplace and the backup mechanisms that we have put forward in terms of ensuring affordability of care to all Americans, whether or not they are disabled.

I believe we have several measures in our plan to achieve those goals. But we will have to pay attention and make certain that the system is in place to come through on the guarantees that we are promising.

Senator RIEGLE. And, of course, part of the legislative tension that exists with the alternative plans is that there is sort of a dividing line between those folks who are willing to impose more discipline in order to capture the system and to make sure the numbers tie out and to make sure you get the efficiencies and you actually see to it that services are provided.

But the other point of view is to say that there should be less administrative control, less compelling cost control measures in place; and in effect, I am not sure, if you think of that as sort of

a teeter-totter and you have one point of view on one side, I am not sure that you can end up with half of one and half of the other.

I mean, it seems to me that you are pretty much in a situation where in order for the system to work that you have laid out, you have to have a cost control regime in there that holds together and it cannot be half a system because a half a system will not work. You have to have a whole cost control system, is that not correct?

Dr. FEDER. Yes, I think that is correct. And I think that as you indicated earlier, you have to have a whole system in that it is achieving universal coverage and security as well as containing costs. They do dovetail and we do need them all in order to make it work.

You talked earlier about complexity. I think that it is difficult to change what is today an extremely complex system. But if we look at our objectives and the way the system will ultimately work for people, I think we can argue that it is vastly simplified if we achieve those goals of assuring that people are always covered and that affordability is guaranteed.

Then individuals will face a far simpler system and the system will work better for the nation as a whole.

Senator RIEGLE. Well, that is going to be part of the dilemma—you know, I have thought about it here in the Senate, because in effect to overcome filibusters and procedural objections which, you know, can kind of proliferate faster than you can keep track of them, it essentially takes 60 votes here and a 60 vote majority is a lot different than a 51 vote majority.

When you start looking at where 60 votes come from off the sort of range of plans and what might be added and subtracted to give you that base of 60 votes so that you can actually turn the wheels here in the Senate, this leaves aside differences in committee jurisdiction, which is another complication, but if we leave that out, just thinking about how you coalesce 60 votes and in effect hold together the essential architecture of the system.

In order words, it seems to me the more I learn and study about it, the more I understand that you cannot surrender the affordability and cost control side and really hope to meet the universal coverage objective. So they are not severable.

And yet as I look at the way a lot of the conversation takes place, they tend to be treated in certain instances as if they were severable and that you can in effect somehow, without very clear cut cost control mechanisms, still end up essentially having a universal coverage system.

I am not quite sure that is how those things get reconciled. I do not think you can have one without the other. I mean, I do not think we can really take everybody in and get a rational health care system going with good primary care and choices and without the discipline on the cost side that would be extremely difficult philosophically and practically to accomplish.

Dr. FEDER. Well, I think that there is little question that unless we move forward to change the delivery system and have everybody participating that it is difficult to have an affordable health care system.

We are strongly committed to achieving those changes and in terms of requiring everyone to participate to guaranteeing them

that their participation will be affordable, which in our plan does include a fall back, if you will, a safety net mechanism for cost containment for limits on premiums as a guarantee.

Although we do believe strongly that it is the market changes that will make these cost containment goals achievable, we have included that guarantee as well and feel that it is important to moving the system forward.

Senator RIEGLE. I guess the other point I would make—and this is sort of in the point of just sort of thinking back and forth here, but I think we have to use these occasions to do that, at least in part—is what I am running into as I talk with citizens in Michigan—and I am thinking particularly of a guy that has a great pizza chain in Detroit called Buddy's Pizza, where I always stop whenever I can as part of my preventive health care program to have a sufficient amount of carbohydrates from pizza when I get to Buddy's. But but the last time I was there a gentleman came up to me and just said out of the blue, whatever you do do not disrupt my health care plan.

He went on to describe a little bit of his. Not that he was crazy about it, but, you know, he has finally figured it out enough that, you know, there is a level of comfort with what it is he has and whatever its defects are, it is familiar and he has come to terms with it and he is very nervous. And you can multiply him by many others—concern about somehow this upheaval in the system, not only forcing him to change, which is always a little scary, but leaving him with something that is not as good as what he has now. That was the paramount concern.

One of the difficulties that I am finding and I am sure you are too is that there is no simple, easy way to explain to somebody what it is they are going to have under the new scheme and how precisely it will work in contrast to what they have today so they can really allay these concerns that they have.

So a lot of it comes back to faith in government, faith in bureaucracy, because there is going to have to be a certain amount of bureaucracy, even if it is bureaucracy in a managed care system. I mean, somebody is going to make the decision, either somebody in a doctor's outfit or somebody in front of the computer screen is going to say yes or no to this or to that.

So I think the wall that we have to get over here is the skepticism about the fact that as bungled as things may be today in the current system, for people they have made their accommodations and in one way or another it is working, even if it is working somewhat ineffectively.

So there is a great uneasiness about a big change, the results of which are unknown in terms of what it will mean for people. We know what it means today, but what does the new system mean tomorrow.

I just sort of state that as a rhetorical point because I think it is the thing we face now. And, of course, the ads that are being run by opponents of comprehensive reform with both cost controls and universal coverage are homing right in on that fear every single day, that either there will not be enough money to pay for this or somebody somewhere in front of a computer screen is going to say,

you know, they do not get this or, you know, their child does not get this.

So I am hopeful that as we go through these discussions and we refine the system and its necessary complexity down to as simple a direct way of presenting it and explaining it, I think we enable people to make the journey with us and not lose them along the way.

It is very, very difficult. I remember being in charge of the Banking Committee with the Chrysler loan guarantee legislation back over a decade ago, very complicated. But it was simple in contrast to this. This is complicated, by far the most complicated problem I have seen in the nearly three decades I have served here.

I think it is going to be very hard for us to stay connected to the public on this because people are swamped with other things. They have to worry about and their families, working, and paying the bills, what have you, to try to fathom how this new health care system really might work for them.

So I guess my point is that I think it is essential that we simplify without oversimplifying down to critical basic points over and over again that really help people sort of make this journey in understanding to the point where they can have enough of a sense of comfort that they see the virtue of the new system as opposed to the current system. I think that is going to be our great test here.

Dr. FEDER. And I think it is one that we look forward to working with you to achieve because I would agree with you, it is the only way that we are going to achieve passage of the universal coverage that we need.

One of the areas that we have spent the most time on is in regard to security of coverage. I think that that is the question people are asking, am I going to hold onto the coverage I need.

One element that the President's plan has that many other plans do not have that we think is part of that is laying out the benefits that people can count on. That has some down sides, too, because people become concerned or critics can point at what is not in as well as what is in.

But it has been our judgment that people cannot have a sense of security unless they know what it is that they get coverage for. I think that we have paid a lot of attention to designing a package that is quite similar to the benefit packages that most well insured Americans have today with the important addition of the preventive services without any cost sharing for children or adults that we have included.

I think that if we talk to people about the benefits they are guaranteed and the portability of those benefits, the continuation of those benefits, regardless of changes in their life circumstances and can persuade them of the affordability of that package as we change the system, and of protections to ensure them choice with accountability that that is the route we have to take.

But we look forward to working with you in making that effective for your constituents.

Senator RIEGLE. One other thought, just an idea that flashes through my mind. That is, one area where we have managed to achieve, I think, a high degree of public support and confidence in the country is with the Social Security system, not that it is per-

fect. And sometimes people do not get their questions answered as quickly as they would like and that all can be solved if we would provide the staff that is needed.

But nevertheless, I think when you look at public opinion polls, if there one thing in government that works that people do not want taken apart or, you know, tipped upside down, it is the Social Security system. So there is actually a high degree of public confidence there.

It may actually be that we would want to think about routing some of the administrative activity through an expanded Social Security system, albeit, you know, a different part of it. This is an agency that has in effect over a period of time developed a level of public confidence. This may be more acceptable to some people who are more uncertain about the prospect of some brand new bureaucracy that is going to be invented and is going to start from scratch and, you know, may or may not work.

I mean, you are going to have to have that anyway. But maybe if it is lodged somewhere where you have a place where there is an established record of a national confidence and know how and administrative acumen, that that might help. I do not know. It is just a thought.

But we have to have the public with us on this. I really view that as a key to getting the 60 votes here that we are going to need.

Dr. FEDER. Yes. Again, I think that we will indeed have to continue to exploit it. I share with you the thinking behind the structure we have put forward. I think that, in fact, reflected some of your own thinking in earlier periods.

Senator RIEGLE. Right.

Dr. FEDER. And the thinking behind having a board of experts is, I believe, really goes at the problem or at the issue of confidence and was intended to indicate that the system needs to be run by people who do have expertise of a variety of kinds in the health system, that because of the backgrounds from which they come they are sensitive to the private marketplace and to varied experience across States, and that their sole function is to address the enormous issues raised by a reform and the continuing improvement in the health care system.

So I think that is the thinking, not to create a new bureaucracy, because the intent is to rely on existing administrative mechanisms, but to have a body, a respected body, at the top whose primary or sole responsibility is for that change. So as you indicated, we, I think, will continue to explore mechanisms, but that is why we are where we are.

Senator RIEGLE. But again, thank you for your leadership. We would not be here as far down this track as we are, I think, without the extraordinary leadership you have helped provide.

Dr. FEDER. Thank you, Mr. Chairman. Likewise, I am sure.

Senator RIEGLE. Thank you.

Let me now call our next panel forward. This morning on our second panel, we have important national leaders and spokespersons for child health advocacy groups and providers of children's health services.

Carol Regan is here with us as the health director from the Children's Defense Fund. We had an opportunity to talk some yesterday and we welcome you this morning.

Dr. Betty Lowe is the President of the American Academy of Pediatrics and is from Little Rock, AR. We are delighted to have you and have just been meeting with some of your colleagues out in Michigan as a matter of fact at the American Academy.

Dr. Irwin Redlener is the president of the Children's Health Fund and a director of the division of community pediatrics at Montefiore Medical Center at the Albert Einstein College of Medicine in New York. We are delighted to have you as well.

And finally, Dr. Randall O'Donnell is the president of the Children's Mercy Hospital in Kansas City, MO, and a member of the board of trustees of the National Association of Children's Hospitals and Related Institutions.

So let me welcome you all. I think we will go in the order in which I have introduced you all. So, Ms. Regan, why do we not start with you and then we will go right down the list and we will make your full statements a part of the record. Feel free to summarize.

Also, if there are points that were raised in the discussion with Judy Feder that you want to comment on, please feel free to do so.

Ms. REGAN. Good. Thank you.

STATEMENT OF CAROL REGAN, HEALTH DIRECTOR, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. REGAN. Good morning, Mr. Chairman. I apologize for my voice. I will make my remarks short.

Thank you very much for holding this hearing on children's health issues and health reform. As you begin to consider the President's Health Care Plan which we have endorsed, and consider bills sponsored by others on the Finance Committee, it is imperative that special attention be paid to the health and medical needs of children and pregnant women.

I want to thank Senator Riegle for his leadership this past year in passing the new immunization plan and for your commitment to assuring every child preventive health care.

We hope that we can look back a year from now and thank you and Congress again for passing a national health plan that includes not only immunization but a wide range of preventive services for children as well as the range of acute, tertiary and long-term care services that every family in America needs.

Every year the Children's Defense Fund compiles and analyzes data on children's health, from access to prenatal care and insurance coverage to vital statistics, such as infant mortality, and low birth weight, and immunization rates.

And every year for nearly two decades we have pointed to the same very simple solutions, solutions that every other industrialized country know to be true, which that prevention and early intervention save money and lives, and that the only way to truly hold down costs is to guarantee universal coverage.

Children who fail to get a healthy start in life suffer health, education, economic and other consequences long after and it is often too late and too expensive to remedy these consequences.

As you said earlier, we have more than 8 million children and a half a million pregnant women every year that go without health insurance. Medicaid expansions, high risk pools, bare bone insurance plans, small market reforms, hospital rate setting—none have succeeded in covering all Americans or in holding down costs.

It is time now for systemwide change. We urge you to pass legislation that is universal for all Americans, not voluntary and less than universal; that is built on an employer mandate; that provides comprehensive, not bare bones coverage; that is affordable and limits out-of-pocket costs, particularly for the poorest families; and that brings clinics and health professionals into the medically underserved communities where more than 20 million children live today.

It is these fundamental principles of health reform which I would like to address this morning.

The first principle, that of universality, is really the guarantee that every American is insured and assured coverage at all times. No insurance company or employer should be able to discontinue that individual's or that family's coverage.

The way to achieve this is to require that everyone participate in the system, particularly that all employers will pay a substantial share of that cost. The President's plan requires that every citizen and every employer participate, and recognizes that anything less could leave millions uninsured as they are today.

Neither the bill sponsored by Senator Breaux, Senate Bill 1579, nor Senator Chafee's, Senate bill 1770, provides that same guarantee. While the Chafee plan does include a mandate, it is on individuals, however, not on businesses. While this has the potential to provide universal coverage, it also could prompt employers who now provide insurance to drop it, resulting in tremendous dislocation, particularly for children who are dependents of those working families.

The plan sponsored by Senator Breaux offers no provision for universal coverage and instead relies on the market and insurance reforms to encourage employers to offer coverage to employees and, in fact, repeals Medicaid, setting up pools for low-income families to purchase coverage, with subsidies based on income.

Some of our concerns about this is that it perpetuates a separate insurance system for the poorest Americans, which we hoped that national health reform would resolve, pooling the poorest Americans in with working families and every other family.

The second fundamental principle of reform is that children receive a comprehensive package of benefits which meets their diverse health and medical needs, taking into account unique needs of low-income children whose health problems, as you know, are compounded by poor health status associated with poverty and whose families do not have the resources to get children care outside of what would be in that basic benefit package.

This is very critical because one in five children today is poor and the numbers are even worse for black children, nearly one in every two black children; and for Latino children, it is nearly 40 percent.

So Medicaid's benefit package, which is the EPSDT benefit package, is something we support coverage for all children. It covers the full range of benefits available in most good private insurance

plans, as well as other services which have proved critical for children, particularly children with developmental, physical or emotional problems.

Neither Senate bill 1770 nor 1579 fully define the benefits family would receive. Each requires that insurance plan cover preventive services, which we fully support, and prescriptions, and eyeglasses, hearing aids, and other services commonly provided in State Medicaid plans, if approved by a Federal board to individuals below poverty.

Yet without a common and comprehensive set of benefits which all Americans have, we would continue to face the problems we have today of cost shifting and of having major gaps in coverage, which will particularly affect the poorest Americans.

The standard benefit package in the President's bill also emphasizes preventive care, but goes beyond the other two plans I mentioned by defining the benefits available to every single American, benefits comparable to a good private insurance plan.

The President's plan also provides additional or wraparound benefits to Medicaid beneficiaries such as hearing aids, and rehabilitation services, the respiratory therapy that you mentioned, which are not included in the standard benefits package.

We would urge the committee to enact a common comprehensive package of benefits defined by law, not subject to a Commission, and to provide children particularly the most comprehensive set of benefits possible, with the residual wraparound for poor and near poor children if a universal package is not comprehensive.

There is a growing consensus that prevention services are cost effective and important to include. But for a child in need of a hearing aid or for a child with cystic fibrosis in need of respiratory therapy, these services are just as critical, and, in fact, could be cost effective as well.

A third principle for reform is that access to care be affordable and funding for premium and cost-sharing subsidies must be adequate and must be stable.

Since the plans that I just mentioned contemplate coverage through private insurance, they are all financed for the most part through flat or capitated premium payments. Given that, we would hope that the committee will protect low-income Americans from paying the same amount as someone earning say $50,000 a year and so would take a serious look at how deep those subsidies would go and to how high they would go.

I would urge you to consider subsidies for those above poverty. We applaud each plan again in its recognition of this. Senate Bill 1759 subsidizes premiums for those people below the poverty level and provides sliding scales for those between 100 and 200 percent.

Senator Chafee's bill starts with subsidies at 90 percent of poverty, and those under 240 percent of poverty will eventually receive subsidies, but only as caps in the growth in Medicare and Medicaid provide the savings to fund those subsidies. And, in fact, the President's plan subsidizes premiums for those below 150 percent of poverty.

In addition, insurance plans with high cost sharing have and will continue to prevent low-income families from getting medical care. A recent Office of Technology Assistance report, which you may be

familiar with, recommended that Congress be cautious about the extent to which cost-sharing is relied on to control costs, especially for sick and low-income individuals. These individuals are the most likely to benefit from receiving health care services at no out-of-pocket costs and the most likely to be harmed by patient cost-sharing requirements.

We would urge the committee to consider nominal fees, similar to those under Medicaid program, for low-income families. Let me just illustrate that with an example of why we feel so strongly about the affordability issue and ensuring that all families, particularly poor and near poor families, have that access.

Take a typical family of four, so with two parents and two children say under five, with a full-time minimum wage worker earning $8500 a year. They would pay an average of $265 in co-payments for doctor's visits and prescription drugs. This is based on some utilization information we analyzed from two national surveys, at $10 per doctor visit and $5 per prescription drug co-payment level.

These co-payment estimates are based on average utilization rates, so families with children with chronic health conditions, for example, are going to experience significantly higher co-payment obligations. When you add in premiums and out-of-pocket costs for the excluded services not in the basic benefit package, these costs could be prohibitive for many families and result in the problem that is so prevalent today—that of families putting off needed care, resulting in higher costs down the road.

Finally, let me mention a few additional issues related to special populations of children. Many children and adolescents in the foster care system receive health care services for the Medicaid program. These children are going to continue to require the Medicaid scope of benefits and will need special attention, particularly since they move around so much, in order to assure that their coverage is portable and their access to health care service is continuous.

Similarly, the many children who live with one parent or live with a non-parental relative, like a grandparent or with non-relatives in informal settings, will also require enrollment and portability protections guaranteeing that where they live, or who they live with, or who is paying the premium is not going to pose barriers to access to health care services they need.

We look forward to working with the committee to accomplish these goals.

After reviewing a number of the bills under consideration in Congress, we have endorsed the President's bill, since it does include the fundamentals essential to assuring the health security to all Americans.

We look forward to working with this committee to achieve these goals, particularly because the health care of millions of children depends on this committee and the decisions you make over the next couple of months.

Thank you.

Senator RIEGLE. Thank you very much. We appreciate, too, the work of the Children's Defense Fund over a long period of time.

Ms. REGAN. Thank you.

[The prepared statement of Ms. Regan appears in the appendix.]

Senator RIEGLE. Dr. Lowe, we are pleased to have you and we would like to hear from you now.

STATEMENT OF BETTY LOWE, M.D., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, LITTLE ROCK, AR

Dr. LOWE. Thank you, Senator Riegle. I am here today as President of the American Academy of Pediatrics, representing our 47,000 physician members who are certainly dedicated to the health of Americans, infants, children, adolescent and young adults. We appreciate the invitation to address the important issues of health care reform and how it is going to affect children.

Let me first take a brief moment though to salute you, Senator Riegle, and this particular subcommittee for your determined efforts to focus the health care reform debate on children. Your tireless commitment to children and their families, especially when very few other people were working on their behalf, has already made a big difference in the quality of some of these children's lives.

Children today face many obstacles in our health care system. One of the hardest, I think, to overcome is how people view child health issues. They assume what is good for adults is good for children. Our record over the past few years certainly has suggested the contrary.

Children are not little adults. They have specific problems, as adults do, and these problems need to be addressed specifically in shall we say children's language.

This importance of addressing child health issues is not simply an act of compassion. Providing children and adolescents access to child-oriented quality health care with an emphasis on prevention is the single most important economic decision that would be made in the health care reform debate.

As you write this legislation, particularly here in your Finance Committee, we feel that you face a choice—I think you mentioned this—to deal with these problems when children are young or America will pay tenfold down the road.

Morally, economically, medically, keeping children well and preventing their illnesses makes sense. It is a constant struggle today to integrate children in our current health system. Children with relatively minor problems, like ear infection, show up in emergency rooms, which is a terribly expensive way to get the care they need.

Children with cancer or other kinds of chronic disease are at constant risk, along with their families, because they stand a constant threat of losing their insurance coverage, if they have it. Young parents have a great deal of difficulty getting their children their routine immunizations.

We do not presume to know all the answers to these questions. But certainly one problem is that our current system is geared toward adult care and we as children's physicians, we are forced to try to fit children into this system every day.

In addition, to the hat as President of the Academy, at home in Arkansas I am a general pediatrician among other things and I see children with chronic disease. I see children with rheumatoid arthritis and that sort of thing.

Telling a family that their child is ill is one of the toughest things that they are going to have to deal with. The illness in itself is enough. But the problem is compounded if I tell a family that a child has a diagnosis of rheumatoid arthritis, I have subjected them to two long-term problems.

One, if they have insurance, they are locked into wherever they get that insurance because they cannot move it. They will never get insurance for that child again. On the other hand, if the 2-year-old did not have insurance in the first place, certainly that I note chronic disease, the diagnosis is going to prevent that family from having that child have any medical coverage. That is a tremendous burden on top of their problems with the illness, per se.

When families have insurance their families have to fight the insurance companies who are today too often making decisions about what, when and by whom their children will get care. These children are being subjected to the thought that if a child has heart disease an adult cardiologist is the one for them to see. That is perhaps the person that is covered in their plan.

Adult cardiologists are experts in arthro sclerotic heart disease and the diseases of adults. Unfortunately, our children have congenital heart disease, rheumatic fever and diseases that perhaps most of the adults do not have; and it is the pediatric cardiologist then who is trained to take care of that particular child. This is a burning issue with us.

These families work with us, pediatricians, and candidly we are being crushed by the avalanche of paperwork and regulations. We spend a tremendous amount of time taking care of paperwork and regulations that could be spent taking care of more children.

The Academy applauds President Clinton, First Lady Hillary Clinton and other members of Congress who are working to put an end to the bureaucratic overkill and to enact health care reform.

You mentioned the problem of the uninsured children. There are a lot of them—9 to 12 million. In 1991, 58 percent of those uninsured children were dependents of full-time, full-year workers. These are the children of working class America. Unless our health care reform addresses these children's health issues in children's terms, all children—your children, my children, all children—are vulnerable.

I know that through your questions you are going to discuss some of the details of the various reform proposals, so let me mention for a moment the report card on health care reform for children that we released a short time ago.

We realize that the current debate is fluid right now, but we thought it would be helpful to provide the members of Congress with an independent snapshot of how children fare under the various Senate health care reforms.

Although there are some significant and meaningful substantial improvements that need to be made, of all the health care reform plans currently under consideration, President Clinton's health care reform plan is the best for children.

We hope that perhaps you can use this report as a measure for assuring us that children do not get lost in this upcoming health care reform debate. It is the Academy's long held position that health care reform for children must include a comprehensive bene-

fit package, guaranteed financial access to the same class of care, regardless of their parents' income, employment or location. No child has any choice as to what sort of family or financial arrangement that he is born into.

Insurance market reforms, such as guaranteed issue and reissue. We believe that it is critical that our health care reform includes a mandated comprehensive benefit package that will emphasize prevention and primary care.

This package needs to spell out the specific benefits that address the unique health care needs of children. In addition, the package must also include a timely schedule for the delivery of these benefits and services for them to be at a maximum cost effective behavior.

If they are not specifically defined up front, children may not get the appropriate benefits or even access. Preventive care, the core of our pediatric medicine, currently is purely covered by many of the insurance companies despite the fact that it has been shown to be cost effective and it certainly is an efficacious medical venture.

A schedule has recently been developed by Maternal and Child Health Bureau in the Health Care Financing Administration called Bright Futures. This will be out early in 1994. This report examined in depth the issue of an appropriate schedule of visits for children in greater detail than has been done in the past.

The use of an age-appropriate schedule of visits for delivery of benefits and services to children is critical to achieve the greatest value. Anticipatory guidance visits, for example, truly can play a key role in avoiding things like injuries, drug abuse, disease and even perhaps detecting or preventing some of our problems with child abuse and neglect. The Academy urges Congress to adopt Bright Futures as a norm for children.

Another issue of great concern to us is the children with chronic illnesses and other disabilities. These children need access to a broad multi-disciplinary group of services. These need to be mainly community based and they must allow the children to participate in all aspects of community life, specially school.

Under the main acute care plan in the Health Security Act, it appears that home health care and rehabilitation benefits, such as speech and occupational therapy are available only after hospitalization or injury. We would like to point out that in this particular language it truly does not address those issues, those diagnoses, those problems that our children with chronic disease have that are in need of this rehabilitative services.

It is true that many of our children who have chronic disabilities can become functioning, productive adults if they receive these services. We recommend that language be clarified to specifically include these disabilities and diagnoses and that some of the more overtly restrictive limitations be modified.

We think to ensure quality health care for children the Academy encourages a concept which we refer to as a medical home. This is a source of regular and ongoing comprehensive health care available around the clock, 365 days a year. This medical home provides preventive care, early treatment of acute diseases and the coordination of care for those with chronic or disabling conditions.

We believe that this is probably best provided by we pediatricians. A feature of this medical home, it gives the child a health care base that they can always rely on and they can turn to. Within that context, it allows us to develop and expand our current practice patterns to include more of a health care team, which can not only take care of children's acute illnesses in a more cost effective fashion, but allows us to integrate some of our activities with those that are going on in the communities such as health education in schools and some of the health benefits that children can receive in schools.

Since this is the Finance Committee, let me address one last subject. We recognize the importance of cost containment in any health care reform proposal. In regard to children, specific cost containment measures should emphasize the benefits from prevention in primary care.

I think we have a problem there because it is very difficult for us sometimes to provide specific dollars. But, for example, several years back when there was an epidemic of measles in Dallas, it was estimated that the city paid more than a half million dollars to take care of the illness associated with those children who had measles.

In addition to that, that does not cover the fact that there were several deaths and there were several children with long-term chronic disease that came out of that epidemic. The unfortunate fact is, that it would have probably cost less than $9,000 to have immunized every single child and prevented the entire epidemic.

These are the kinds of figures and cost containment that we know we can achieve, but it is very difficult to come up with specific examples.

We know that when health care is delivered in appropriate sites, site costs can certainly be radically reduced. If children are seen in physicians' offices instead of the local emergency room, that is an obvious cost saving. Probably the cost in emergency rooms is two and three times the cost of the office visit.

In addition to that, in response to some of the concerns about having health maintenance visits in the core package, let me just say that as a general pediatrician, if I see 100 teenage female girls as a health maintenance kind of a visit, maybe I can be particularly lucky and effective and I will prevent perhaps 10 of those girls from becoming pregnant and being a teenage mother.

Now those 100 visits would probably cost around $3,000 to $4,000. On the other hand, let us take the prevention of the 10 pregnancies. One of those girls would probably have a 2-pound premature, which would probably cost us around $100,000, much less the possibility then of long-term chronic disability.

How much we can also save in regard to prevention of sexually transmitted disease, drug abuse, encouraging children to finish school, et cetera, all the things you do in health maintenance visits, again, you cannot put a dollar amount on those kinds of preventive services today.

In closing, we feel that we are faced with a historic opportunity to reform our health care system. The Academy believes that providing all children and adolescents access to child-oriented health

care should be the foundation upon which meaningful health care reform can be built.

Health care reform for children is really about giving children a chance to reach their potential in life. If we can keep our children healthy, they can have a fair shot at education, which also happens to be critical; and then they can make the best of their lives. That is all anybody can ask for.

The 47,000 pediatricians in the American Academy of Pediatrics earnestly look forward to working with the President and this committee as health care reform moves through the legislative process.

Thank you.

[The prepared statement of Dr. Lowe appears in the appendix.]

Senator RIEGLE. Thank you very much. Let me just ask you one question before we go on. That is, do you now practice by yourself or in a small group practice?

Dr. LOWE. No, interestingly enough, I participate in a group practice which is really the faculty of University of Arkansas School of Medicine, so we have a large group.

Senator RIEGLE. Have you done that for a long period of time or were you in the private sector?

Dr. LOWE. I was in the private practice for about 10 or 12 years and I have been a current faculty member now for about 17.

Senator RIEGLE. But to somebody who is a practicing pediatrician, as you were before joining the faculty, would you now under the plan that has just been laid out, you would have to be thinking about how you sort of hook into an alliance, would you not? How does that sort of strike you?

Dr. LOWE. I think we are like the guy you talked about in the pizza parlor. All of us realize that there is going to be tremendous changes in the way we practice medicine, so we are apprehensive and we do not know necessarily how it is all going to quote "work out."

I think that in practice that we could see that the children we take care of will have such a marked increase of benefits and a much more viable way to have their health care costs covered that we can tolerate some fluctuation in how we practice.

We feel that as primary care providers we would have no problem fitting in the accountable health care plans, for instance. We have a valuable service to contribute. We think that we can fit into those and we think that we can also develop a posture where we can have some say as to what the children actually do receive in the various plans.

Senator RIEGLE. Has the Academy thought through the issue of how many pediatricians are likely to stay, you know, in a sense on their own or maybe with this group of three or four other pediatricians versus those that practice, in essence, fee-for-service medicine versus those that are in a sense going to go into an affiliation with a broad health alliance and, you know, the different kind of an approach that that may bring with it.

Dr. LOWE. I do not think at the moment we would have any clear handle on how many pediatricians would stay in the current fee-for-service. I think a fair number will, particularly in the smaller communities. In the smaller communities where you are the only

group in town or you are the only pediatrician, you are going to stay in a smaller system.

We have seen somewhat of a trend over the last few years that more and more pediatricians are participating in some of the current HMOs, et cetera, which is a more salaried thing. It all depends on what our younger generation of physicians coming up think is the most viable life style for them.

It is not going to be so much what pediatricians my age think, it is what our residents and young pediatricians think. They will judge a lot of their decisions, I think, on life style.

Senator RIEGLE. Thank you very much.

Dr. Redlener, we would like to hear from you now, and we will make your statement a part of the record. We would like your remarks.

STATEMENT OF IRWIN E. REDLENER, M.D., PRESIDENT, CHILDREN'S HEALTH FUND, AND DIRECTOR, DIVISION OF COMMUNITY PEDIATRICS, MONTEFIORE MEDICAL CENTER, ALBERT EINSTEIN COLLEGE OF MEDICINE, NEW YORK, NY

Dr. REDLENER. Thank you very much, Mr. Chairman. My remarks have been getting shorter and shorter as we listen to other speakers. I am going to try very hard not to be redundant, but the fact of the matter is that I think that most pediatricians and most people that care about children's health issues are really speaking in some ways off the same page. And, in fact, I know you are coming from that page as well. So I consider this a pleasure to be here.

I will try to just focus on the issue that is of particular concern to me and my organizations which has to do with the most severely disadvantaged children in the country in terms of their access to medical care and what happens when they do or do not get that.

As a way of background just briefly, in New York we run the largest health care program for homeless children in the United States, but we have also started and support mobile-based primary care, pediatric programs for homeless as well as housed indigent children in urban communities in Newark and Dallas and Washington, DC's Anacostia section and south central L.A., as well as some very rural programs in the Mississippi delta region and western West Virginia and in the hurricane ravaged part of south Florida.

But all of the programs that we do operate have as a common denominator extremely disadvantaged kids who have had the most severe problems in accessing health care that one can possibly imagine. So I am going to run through a few points that really relate to that particular population and then try to conclude with a few principles that I think have particular bearing on these children and how all this relates to the health reform proposals on the table.

I will tell you in advance that we are really quite pleased about the President's plan and feel that it answers, in essence, all these central concerns that have to do with these children. I will try to tell you why that is.

My essential concern here is that our country at this particular time in history has virtually an entire generation of what I would call, to take off on what Betty Lowe just said, medically homeless

children. I am going to explain this statement and tell you why we have this problem and what this has to do with health reform.

In order to understand what a medically homeless child is, it might be worth just repeating what Dr. Lowe just said about the absolutely necessity of children, all children, severely disadvantaged, including the well advantaged, to have what we are referring to now as a medical home, which is this comprehensive prevention oriented community-based place where health care is received in a comfortable, compatible manner for families, where medical records are kept, where whole health care is organized on behalf of a child and a family.

And under that organization we are able to do things like track immunizations, most appropriately care for kids with chronic illnesses; and to put it another way, deliver the right kind of care at the right time and in the right place. And to put it just a third way, we are talking about the kind of care that is routinely available to people in mainstream pediatric practices that many middle class children enjoy in this country, and they should enjoy, but which many underserved, especially economic disadvantaged and some racial minority groups have not enjoyed to the extent that they should.

So in the context of this description of what I would consider to be an appropriate medical home environment, therefore the medical homeless child in a sense is a child with no identified stable place of reliable health care. it was, therefore, relegated to getting care in emergency rooms when care is usually too late.

Senator RIEGLE. Can I just ask you one question?

Dr. REDLENER. Yes.

Senator RIEGLE. Based on your research or your own sense for the history, if you were to go back to the 1960s, for example, how many kids in the country would have been medically homeless children I mean, either in number or percentage of kids versus today.

In other words, what does the trend line look like as nearly as you can judge, say, over the last three decades?

Dr. REDLENER. I think the trend line in essence to a certain extent follows the level of increase in child poverty in the United States on the one hand; and secondly, also follows the trends to fewer and fewer people, relatively speaking, having health insurance coverage.

There are some other complex issues involved here, but I think the numbers at this point are really quite staggering. In effect, as I was going to explain in a second, that I think it is really we are dealing with at least 20 to 25 percent of our population that is currently not getting what I would consider to be, and I would suggest that many pediatricians would consider to be, an appropriate place and array of health services.

I think it is really an enormous problem that we have not really appreciated. But it is very important now that we are on the brink of really reforming the nation's health care system that we finally and fully bring these children and families into an appropriate level and organization of health care.

I think that as we go through this, it is clear that when we look at where children are getting health care today in the United States, one place is in the emergency rooms, as I was saying, where

it is extraordinarily expensive to deliver health care. But it is also not even very good.

Unless you have a life-threatening illness, you do not belong in an emergency room. And especially as a child, you need to be kept out of emergency rooms and into the doctors offices and clinics where appropriate prevention and comprehensive care can be delivered.

The other thing we have done to children who are medically homeless is, we have provided a tremendous amount of what we would call categorical care. You know, we will get an immunization drive here. We will touch some kid. Or a lead screening program or somebody will do a TB testing, it is all this sort of random, chaotic delivery of services which are in essence health care and what I have referred to as health care in fits and starts. That is an absolutely terrible way for children to get health care.

The consequences of all this random chaos in how many children, especially poor children, get health care are some results that are very upsetting to us. I think we have been reacting to many of these consequences in the wrong way. Some of these consequences include things like when we look at the immunization situation in the United States, we are seeing that in many of our cities 60 to 70 percent of the children at age 2, for example, are not up-to-date in their immunization schedule.

But what we do not actually realize is that on top of that we have probably millions of children with the chronic conditions that Dr. Lowe has referred to who are disadvantaged who are not in medical homes and, therefore, not getting appropriate attention to those chronic conditions.

We see every single day children with asthma that are so short of breath they cannot get up the stairs to go to the places where they are staying in the welfare hotel. They are too exhausted and short of breath to do their homework. This kind of situation is absolutely atrocious. My feeling is, it is directly related to the lack of an appropriate medical home environment for them.

And even on the acute conditions—this absolutely staggering to me—we see at least 100 children every single year in our New York project alone who are kids who come to us because they have been reported as having learning disabilities or behavioral problems. We find out that they cannot hear well. They cannot hear well because they have chronic ear infections. They have chronic ear infections because they have not gotten their acute ear infections treated.

They have been to an emergency room where there are some antibiotics being given. There is no follow-up and it is an absolute disaster. So for the lack of a little attention in a comprehensive health care environment, we have kids who are actually failing in school and will, I propose, go on to be far less productive, happy citizens of this country in not too many out years from now.

I think in terms of the numbers that you started to ask about before, let us assume that there is 10 million or so uninsured children in the United States. There are some number of millions who are underinsured, where their families may have insurance, but that insurance policy may not cover the prevention and comprehensive care that children need.

Besides that, we are dealing with probably a million to 2 million homeless children, migrant kids, kids who are living in absolutely atrocious, isolated, rural poverty environments or more startling kids on Medicaid by the millions where there are no Medicaid providers or very few Medicaid providers. So in essence they may have the insurance card, but they certainly do not have the health care.

I think all this adds up to a good 15 million children and we only have about 65 million kids in the country. I think it is an intolerable situation.

Now what I have seen in looking at the administration's proposal here that has bearing on this problem is that first of all that we clearly have guaranteed universal coverage and that is absolutely something that must be a part of any health reform package.

Secondly, as has been mentioned by a couple of people, the absolute necessity to have a defined, articulated, detailed benefits package that we all can look at and understand and see whether it covers the prevention and comprehensive care that is needed, to see if it, in fact, is providing what we are calling this medical home. It is very important that that be on the table.

I would, in essence, if it were up to me, reject out of hand any kind of proposal that does not absolutely and in detail define the benefits for children.

The third thing I see in President Clinton's proposal is a very revamped and extraordinarily well-enhanced public health infrastructure that will actually bring to the table support for many of these enabling services that will actually let the people who do get health insurance get the care they need—the transportation, the translation, the child care, whatever it is they need.

And furthermore, that this new public health vision includes a significant amount of resource development to provide those facilities and structures to allow health care programs for children develop where they are needed.

And finally, the other thing I see that I like a lot in the President's plan is significantly more money for the National Health Services Corps, community health centers, the development of primary health care providers through a number of mechanisms. I think all this makes me a believer in what is being presented here and I think wanting to support this.

What I am very worried about, however, is that if some of the basic principles are not safeguarded through what is going to be, I am sure, a grueling Congressional process, will we be left with something at the end of this that does reflect what is in the President's bill, which I know is what is in your mind what should be health care.

I would like to just in conclusion, in essence, mention what I think those safeguarding principles need to be. First of all, is that if in fact we are not going to have a children first kind of approach to this, which I think is not in the President's bill and probably might be difficult to work out, then at least what we must insist on is a very fast track to universal access. The faster the better.

I think January 1, 1998 is sort of the outside date that I would like to see; and I would like to see it, in fact, happen much sooner.

The second safeguarding principle is that we are depending upon the friends of children in the Congress, I think, to make sure that

the children's benefit package in the President's bill, or whatever bill, does not get eroded by the actuarians who are going to come around and try to chop things off to save money. I do not want to see the money saved in health care reform come on the backs of children, especially those disenfranchised children who have really taken it severely over these last few decades.

The third principle has to do with safeguarding those public health system enhancements that I just mentioned, especially around the enabling services that will really make the difference between simply having insurance coverage and actually getting health care. We are hoping that can be attended to.

Now, the fourth thing I want to mention I think is a little more arcane, but to me may be more important than all the rest. it is very important to me that as we lay out a plan that has State flexibility in the face of Federal guidelines, it is very important that the reform principles not be allowed to be undermined by State's rights to create a flexible response to these Federal guidelines and, in fact, undermine the assurances that all children will actually get health care and health care of a comprehensive type.

I guess when the dust of flexibility settles, we should not see poor or minority kids in the delta of Mississippi or Arkansas for that matter having second class health care or no health.

So who is going to make sure that as we fall all over ourselves to make sure that States are comfortable, that the plan is flexible to allow them to do what they need to do, that we will, in fact, still have at the end of that road the assurances that everybody is going to be in the system and especially the children who need to be in that system.

In terms of the other plans on the table, I think all this has been articulated enough, although the one plan I have not heard anybody say anything about is the single-payer approach which has not been discussed very much here.

I want to say for a couple of reasons that we should make at least a brief comment about single-payer approach to this, primarily because I come from a very, very strong single-payer advocacy perspective and undergone some kind of transformation over this last year or so; and secondly because I know the significant Congressional support for single-payer; and thirdly because I know there is great public sector very actively in support for single-payer.

But here is the problem with single-payer as it affects children and children's health care and especially disadvantaged kids. Number one is, the single-payer, Canadian style health reform encourages solo providers to do their thing. The solo practices in counter based medical practice—I did something; here is the money for it; and thank you very much.

It discourages, in fact, health care team work. And health care team work, as far as I am concerned, is absolutely essential to making sure that we have good comprehensive organized health care, especially for children with chronic illnesses and kids who are disadvantaged.

The second problem with Canadian style single-payer reform is that it is a system that is very encounter driven, as I just said. But America has 70 percent of its doctors as specialists, only 30 percent

generalist. If tomorrow we instituted single-payer on our current system, we would have a specialist driver encounter fee-for-service system that would be an absolute nightmare to control and to keep costs under control. I think that would be a major problem.

The third thing is that in single-payer it is very difficult, in fact, to ensure quality and oversee utilization without having a massive regulatory bureaucracy. I could get into more detail about that if you wish. But I think that really is a problem.

The final problem is, there is nothing about fee-for-service single-payer style health care is that a panacea for underserved areas. In fact, you have to go through a whole series of incentive issues and all you end up with is a lot of single, solo practices in areas of need. I think we actually need more than that. And certainly our underserved children need much more than that.

So in conclusion, I am just going to say that I am deeply concerned about the fate of underserved and disadvantaged children in the United States when it comes to health care reform because for the last 2½ decades I have been dealing with their problems in a variety of settings, starting with my first job running a Vista clinic actually in east Arkansas of all places until today dealing with these problems in urban and rural America.

I am hoping that you—and knowing you and your history personally—no doubt will do whatever you can to safeguard the very basic principles I mentioned and try to make sure that when we get finished with all this that the children who have been very much in the back of the bus have a front seat in the new vision.

Thank you.

[The prepared statement of Dr. Redlener appears in the appendix.]

Senator RIEGLE. Thank you very much.

Senator Danforth, our last witness this morning, Dr. O'Donnell, of course, is here from Kansas City. I think you might want to make some remarks about that.

Senator DANFORTH. Well, thank you, Mr. Chairman. I did come here expressly to see Dr. O'Donnell. I am sorry that I was not able to be here earlier in the hearing.

But Dr. O'Donnell is the President of one of the great institutions of our State—Children's Mercy Hospital. He has been very, very generous with his time and with his good words in providing me and members of my staff with a lot of input in the area of health care, particularly with respect to children. I am very happy to see him here today.

Senator RIEGLE. We are delighted to have you and we will put your statement in the record. We would like your remarks now.

STATEMENT OF RANDALL L. O'DONNELL, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE CHILDREN'S MERCY HOSPITAL, KANSAS CITY, MO, AND MEMBER, BOARD OF TRUSTEES, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, KANSAS CITY, MO

Dr. O'DONNELL. Thank you very much, Mr. Chairman. I am delighted to be here and appreciate your interests in children's health care and am particularly appreciative of Senator Danforth's dedication to the children of our state. We have had the opportunity on

several visits at Children's Mercy Hospital to discuss health care reform.

I am also a Trustee of NACHRI, the National Association of Children's Hospitals and Related Institutions. We also appreciate the opportunity to testify on its behalf.

Children's hospitals play an essential role in the delivery of care to the most vulnerable of children—the sickest, the poorest, and those with the most specialized care needs.

Children's hospitals also play other essential roles because they train the next generation of pediatric health professionals and they are engaged in medical research for children. We bring two fundamental observations to the health care reform debate.

First, children desperately need comprehensive health reform because they are at the front lines of erosion in private health coverage. Second, health care reform must be tailored to fit children's different health care needs because when it comes to children's health care one size will not fit all.

I would like to discuss each observation in more detail. Children need comprehensive health care reform. Studies show that in the struggle to cope with rising health insurance costs, both employers and individuals often draw the line first at paying for dependent coverage which hits children the hardest.

As a consequence, more than one in three children now depend on either Medicaid or on charity to pay for their health care. That proportion continues to grow. Thanks in part to the efforts of this Subcommittee, Medicaid has become the nation's health care safety net for children. But many States are stretched to the limit by their Medicaid programs. Medicaid and charity are not a financially sustainable safety net.

Children also are at the front lines of change in the health care marketplace, which is rapidly converting indemnity coverage to capitated managed care. Many States want to enroll all Medicaid recipients into managed care plans. Since children and their mothers account for 70 percent of all Medicaid recipients, they will be affected the most by these state-wide experiments.

Health care reform is needed to give all children comprehensive health benefits and to influence the way care is financed, so that benefits translate into access. Children's hospitals look and feel different. These differences might be summed up by the slogan, "when it comes to children, one size will not fit all."

We tailor health care to fit children's needs. Health care for children is intertwined with the biological processes of growth and development, while for us as adults health care is enmeshed in the process of trying to delay our falling apart. They, therefore, must also tailor health reform to fit children's needs.

I would like to give you four examples where there appears to be bipartisan consensus. My first example involves standard benefits. Leaders in both political parties advocate a standard benefit package for all Americans, with emphasis on primary and preventive care. That commitment is sure to benefit children for whom such care is the most cost effective, if it provides a true medical home, as Dr. Lowe and Dr. Redlener have already mentioned.

However, as experts in the care of children with special needs, we know that it is equally important to focus attention on how the

benefits will cover the needs of the child with a chronic or congenital condition, such as cerebral palsy.

For example, if standard benefits limit coverage of rehabilitation to treatment of illness or injury as has been discussed, they could be misinterpreted to not cover birth defects which result from neither illness or injury. That is why children's hospitals say that standard benefits must be tailored to fit the needs of all children.

My second example of the need to tailor reform for children involves managed care. Leaders in both parties believe that in order to restructure health care delivery, we need to enroll more people into risk-bearing capitated health plans. We should give plans an incentive to manage the care needs of individuals cost effectively by giving them a single fixed payment per capital adjusted for the risk of the individual.

Managed care has great promise to meet the needs of children if the financial incentives facilitate their access to primary and preventive care. But if it is purely cost driven, capitated managed care can have the opposite effect for children, denying them access to appropriate care instead of assuring it.

Because so few children require hospitalization, they depend on regionalized centers more than adults. These regionalized providers also carry the added costs of caring for low-income patients, training future health care professionals, conducting medical research and caring for the sickest of patients.

In some markets, managed care plans refer only the sickest and most expensive patients to children's hospitals and other pediatric facilities. Other plans seek to prevent children's hospitals from contracting with more than one plan, preventing the hospital from serving a large enough population to sustain its comprehensive services.

The fact is, many of the protections built into managed care—risk adjustment, measures of quality and outcomes, for example—have not been developed for children. If reform is built on capitated managed care, it should manage the competitive market to ensure children's access to the care they need.

For example, health plans should provide access to appropriate pediatric subspecialists, not just adult specialists. Health plans should allow pediatric specialty providers to contract with multiple plans to maintain financial economies of scale and promote medical proficiency in the care of children.

Health plans should contract with hospitals that have demonstrated their effectiveness in serving low-income people. Reform should also separate the funding of graduate medical education from patient care and recognize the role and unique costs of teaching hospitals.

And finally, when health plans account for the cost and quality of their care, they should do so in terms specific to children.

My third example of tailoring reform to children's needs involves cost containment. There has been much debate about whether and how to cap the growth in health care spending nationwide, as well as to regulate insurance premiums. But there is no debate about capping the growth in Medicaid, at least at a per capita level. That is the equivalent of a defacto spending cap on health care for children since half of all Medicaid recipients are children.

Therefore, it is important to talk about the need for cost containment to fit children's needs. Children have different health care resource requirements than adults have. Nursing care is the largest single expense in hospital care. For every hour in any hospital, a charge on average requires 31 percent more routine nursing care than adults.

Children's hospital patients require even more resource intensive care. They are younger, sicker, and more likely to have a chronic condition than children in general hospitals.

However, too often strategies to cap health care spending fail to take into account these differences. We see proposals to cap national health spending based on an extrapolation of past spending rates, in which the cost of children's and adult's care have been averaged together.

Most advocates of capitated payment for health care have recognized the need for risk adjustment. Without such risk adjustment a health plan or provider who cares for a population that is disproportionately at risk would be financially unstable.

However, risk adjustments specific to the needs of children, particularly children with special care needs, do not exist and will take years to develop. We must begin now to invest in risk adjusters for children as we embark on health reform.

That is why children's hospitals believe spending caps should be based on need, not historical trends, and adjusted for the risk of the child with special care needs, not the risk of adults with similarly named diagnoses.

My last example of the need to tailor reform to children's needs involves Medicaid, which is the Nation's largest and most important child health program. No single program, public or private, affects more children nationwide or more children in children's hospitals. Therefore, it is especially important that great care be given to how health care reform transforms Medicaid.

For example, many leaders in both parties want to eliminate Medicaid disproportionate share payment adjustments. They argue that these payment adjustments are only needed to pay for the cost of care of charity patients.

However, for children disproportionate share payments represent something entirely different. In most States, including Missouri, the Medicaid program makes disproportionate share payment adjustments because the base Medicaid rate is inadequate to cover the costs of care. They are critical to the ability of children's hospitals to play an essential role in providing access to care to children of low income families.

In conclusion, Mr. Chairman, we are indebted to the members of the Subcommittee for your past efforts to strengthen Medicaid for children and for your new efforts to achieve comprehensive reform. We are also indebted to President Clinton and Hillary Rodham Clinton for their efforts to make health care reform a national priority.

We support many of the principles upon which the administration's proposal is based and we believe it is a good place from which to start to build a coalition for reform.

Thank you for the opportunity to testify and I would be pleased to try to answer any questions you may have.

[The prepared statement of Dr. O'Donnell appears in the appendix.]

Senator RIEGLE. Thank you very much.

Let me just start right in where you finished. Tomorrow I am going to fly out to California to visit my grandson, an eleven-month-old grandson, who is in the Children's Hospital in Los Angeles, after encountering a terribly difficult medical emergency that has really created—nearly lost this little fellow about 3 or 4 weeks ago. He is making something of a recovery.

But he took a real jolt to his brain in the process of his system being interrupted by the medical problem that he had, which has since been fixed. But in any event, I was able to watch the life giving care in that children's hospital.

I have an 8½-year-old daughter who when she was had a very serious appendicitis which was not easily found and finally the Children's Hospital here found that problem and solved it. But she was in the hospital for many days.

So I have had the opportunity myself, not just through constituent experiences, to see children's hospitals from the inside when the lives are on the line. I am very struck by the all across the spectrum of care from the pediatricians who are maybe single practitioners or in a group practice now teaching others in the children's hospitals and the effort by both the Children's Defense Fund and the outreach that you, Doctor, and your colleagues are trying to do is ranging across the country from Mississippi to New York City, wherever.

I am struck by the need for us to have not just universal coverage and protection and good primary care, but to make sure that we are equipped to deal with the special situations that arise as they just do. The children's hospitals remind me very much of the school of the deaf in Michigan that I attended one time and how these problems cut across all groups of all economic levels. One place where you find everybody mixed together is in places like that where you have acute problems.

It seems that in many cases a lot of the tougher problems are in our low-income families and children, gravitating in with serious situations of one kind or another into children's hospitals.

I have some concern as to what happens to children's hospitals under this kind of managed care system and the degree to which as these affiliations take place groups are formed. How do we take sort of free-standing operations like children's hospitals which are really specialized care institutions in a sense and make sure that they not only can continue to function strong, professionally and financially? How do we make sure that they do not somehow get end played as these alliances are getting put together?

It seems to me like a children's hospital ought to be a natural adjunct to any health alliance that is going to be out there because we want to be able to route kids on through that need that kind of intense, specialized sort of pediatric and children's focus. Is that not right?

Dr. O'DONNELL. Well, I think there are basically three approaches to addressing the dilemma that you are talking about, Mr. Chairman. I think that one avenue that is available in the ad-

ministration's proposal involves the designation of essential community providers.

We certainly believe that children's hospitals by definition should be recognized by any health care plan as an essential community provider and utilized as such.

I think the second avenue that we need to approach is that we need to recognize that every children's hospital has a huge fixed cost investment in providing an availability of services. One of the shortfalls that we have had in our current environment is that we are only reimbursed on the basis of utilization and not providing an availability.

Let me give two examples. In any hospital that has an emergency room, there is a fixed cost for having that facility available and staffed with the appropriate equipment 24 hours a day. Those costs are going to be incurred by the hospital whether they have a patient or not. Children's hospitals certainly have an emergency room, so they experience that side of the cost equation.

The second area though where it becomes particularly acute in a children's hospital is that we provide unique tertiary care services. Let us say, for example, that you have a child who comes into the hospital in the middle of the night, 3 o'clock in the morning, and the child needs open heart surgery.

You cannot just call up a temporary service and say, would you please send over a pediatric cardiovascular surgeon, a team of nurses, perfusionists, and the appropriate equipment. It just does not happen. You either have that service available or you do not. There is a significant cost tied to that availability.

So the avenue that I would suggest is that the health care plans involve the children's hospitals in the risk-sharing pool. They share the capitated payment as opposed to just being a vendor of services and therefore be paid on the basis of utilization.

Then the third element that I think is so important to maintaining the community presence of the children's hospital is that we separate out the costs of medical education. This is a cost that is somewhat difficult to get at. It has been hidden over the years. But all of our children's hospitals serve as the teaching ground, sometimes the only location for a University Department of Pediatrics, for example.

Those costs are borne by the children's hospital. It is very difficult to be competitive in a managed care market when you have to include those costs as part of your charge calculations. So I believe that those three elements will be significant in helping to assure our survival.

Senator RIEGLE. How many children's hospitals are there across the country?

Dr. O'DONNELL. There are approximately 100 children's hospitals and in the neighborhood of 40 to 50 that would be comprehensive in nature. Not every State has a comprehensive children's hospital.

Senator RIEGLE. It is so interesting, this experience that we have gone through, not to overly personalize it, but you know you learn from these things and you can see what is going on, not just through the cases of other people.

But when my little grandson became so sick and his stomach actually sort of had gone through his diaphragm up into his chest

wall, and so it interrupted. He needed emergency surgery for that. It is a very complex problem and not an easy one to spot or to fix, as you say. At 3 o'clock in the morning you need a team and you cannot really be thumbing through the yellow pages to find what you need if you are going to save a little tyke that is in that situation and they very nearly did not.

I mean they managed to in this case but only because there was a team at the ready that once the problem was diagnosed, as exotic as it was, could go in and do a lot of stabilizing events, including neurological damage that was occurring because of the interruption of the flow of body fluids.

And now, of course, you know, having survived that crisis, there is the whole rehab side of what happens with a little tyke that goes through this kind of jolt. I think the ability for us to understand the range of these problems and to make sure that the areas where we made the gains we do not lose them, you know, the things we have done that are good and really meet needs, are not compromised in a plan of this kind.

I think one of the difficulties is that when the legislative process is never a neat, orderly process anyway. I mean it has been likened many times by many writers to a sausage factory, you know, where everything gets sort of gets fed in and the wheels turn and out comes the sausage and you hope it is close to right.

I think in this instance, you know, we have so much at stake here in terms of the public health and the affordability in the coverage issues that we have to exercise some considerable care to make sure that we do not grind things up in the process that we did not have any intention to impairing.

I think children do stand out. I think we do not do a very good job in America today of looking after the needs of our children, whether they are the medical needs or other social and community needs. In some respects I think we have thriving pet industries in this country, and as well we should because people love pets—dogs, cats, whatever—and a lot of money is spent on food formulations of all kinds. I mean you can get an endless variety of cat foods that will take care of every conceivable kind of nutritional need that a cat might ever have and that is all part of our system.

But, you know, I think in the rush of contemporary life, kids are not doing all that well generally speaking, partly because families are not. Families are under tremendous pressure. There is this huge backwards slide economically for so many families in the country.

Just the number of homeless children that you site, you know, the numbers are really stunning, to think about kids that are in effect roustabouts and they are going from shelters or, you know, living in cars with their parents. I mean, these are not uncommon circumstances today, whether it is New York or Detroit or wherever.

I think where we have things in place that work, I want to make sure that we hold that ground, I mean that we nail that down, and not have that sort of compromised in the process, but to go on from that to start to pick up the rest of the unmet needs. That, to me, is the real promise of health care, is to finish the job and not to compromise any part of the job that is now being done.

I worry some about just the sheer complexity of the nature of this problem. When you are trying to correct so many things at once, it is almost impossible to get it exactly right. So I want to make sure that in the area of children, who really cannot fend for themselves very well, that we are not surrendering any ground.

I want to make sure we hold all the ground we have and then I want to sort of take some new ground here, if you will.

So I want to thank you for your testimony today. I would hope, too, that as we go down the track here that you will continue to give us your thinking because there will be twists and turns in the road. I would like to continue to get your input beyond just the statements of today.

My staff is here and we will be spending the lion's share of our time on these issues to try to make sure we get them right. So we will welcome your guidance and your concerns as we go down the track here.

Let me thank you again for testifying, for your leadership, each of you, in your respective capacities and for coming today.

Ms. REGAN. Thank you.

Dr. LOWE. Thank you.

Dr. REDLENER. Thank you.

Dr. O'DONNELL. Thank you.

Senator RIEGLE. The committee stands in recess.

[Whereupon, at 12:17 p.m., the hearing was adjourned.]

APPENDIX

Additional Material Submitted

Prepared Statement of Judith Feder

Mr. Chairman and Members of the Committee: I am pleased to come before you today to talk about benefits for children under the Health Security Act. The commitments for children set forth in the Act represent the best of what President Clinton has pledged for our nation.

America's children face unprecedented challenges today:

- 9.5 million American children have no health insurance.
- immunizations for children under the age of two are only 40–60 percent, with some urban areas reporting rates as low as 10 percent.
- one in five American children had no contact with a doctor in 1992.

THE HEALTH SECURITY ACT

Mr. Chairman, we all agree that the nation must address these problems. I am pleased to come before you today to talk about how the President's plan addresses our most vulnerable population and one of our most valuable resources—our children—and how the Health Security Act provides services and benefits that will enable our children to stay healthy.

The Health Security Act guarantees that all children will have comprehensive health care coverage. The Act provides a benefits package which includes a broad range of health services and which prohibits plans from excluding children (or anyone) due to pre-existing conditions.

Prevention is the cornerstone of the Health Security Act. The comprehensive benefits package includes a wide array of preventive services not covered by the majority of today's insurance plans—immunizations, well-baby care, and other screenings and early detection measures—which will prevent health problems or help resolve them before they become serious illnesses.

Our first investment in healthy children is good prenatal care for mothers. To remove any financial barriers to these critical services, the Health Security Act provides for complete prenatal care with no cost-sharing.

The Act also provides all children full coverage of well-child care; immunizations and preventive services with no cost-sharing. These guarantees are essential to ensure that all children get off to a healthy start. Also important to serving children, the mental health benefit includes as part of its broad array of services coverage for therapeutic family and group treatment homes, day treatment, home-based and behavioral aide services, case management, and collateral services.

PROTECTING LOW-INCOME CHILDREN

Under the Health Security Act, low-income families will have the same choice of plans as other families in their area and providers will receive the same payment regardless of the income status of the family. Families who today receive health care through Medicaid will join the alliance and receive assistance in paying premiums to ensure that their insurance is affordable. Eligible low-income families will also receive assistance with cost-sharing.

Every American, including those who are so poor that they currently qualify for health coverage under Medicaid, will be able to receive the federally guaranteed benefit package. However, we recognize that some children who are covered under Medicaid currently receive some services that go beyond the new array of benefits. In an effort to ensure that there is no gap in service for low-income children, the plan includes a new, capped, federal program for poor children with special needs.

We are contemplating that this "wrap around" program will have uniform federal eligibility criteria, roughly structured on current Medicaid criteria, and that it will cover a federally determined set of services for eligible children under age 19. Basically, the services will include Medicaid services that are not included in the comprehensive benefit package, such as hearing aids, transportation, and some therapies.

PROTECTING CHILDREN WITH DISABILITIES

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all children and families in America. But families who have children with chronic health problems or severe disabilities face special challenges. In talking with parents of children with disabilities—costly disabilities—I have met many families who have shared their stories with me. A single mom with two children with cystic fibrosis whose insurance premiums nearly double every year. The parents of a six-year-old whose extensive need for medical supports have exhausted the lifetime limits of their insurance coverage. The mother of twins born prematurely with cerebral palsy, seizure disorders, and mental retardation, who has no insurance at all.

Outlawing pre-existing condition exclusions will help these families enormously. But many of them need more—they need long-term supports to help them keep their kids at home, in the family, in the community. Families are not looking to be replaced by a service system—but they need some reinforcement. They need a real choice beyond institutionalizing their children or bankrupting the whole family to keep their children at home. The plan offers real hope, in the form of a major new expansion in community-based long-term care.

One set of uniform eligibility requirements will exist across all states. Children can qualify for this program if they are in one of the following groups:

- children under the age of six who would otherwise require hospital or institutional care; or
- individuals with severe or profound mental retardation; or
- individuals with severe cognitive or mental impairments; or
- individuals who need hands-on or stand-by assistance, supervision, or cuing to perform three or more of five activities of daily living (eating, dressing, bathing, toileting, and transferring.)

The new long-term care program, which represents a major increase in spending for community-based long-term care, will provide a range of community supports to people with severe disabilities, regardless of their age or income. This new program will be financed jointly by states and the federal government. However, it will differ from Medicaid in that federal match rates will be higher but capped, you will not have to be poor to qualify, and the program will be highly flexible.

The new long-term care program is designed to build on state innovation and creativity in responding to the needs of people with severe disabilities and their families. The range of services that may be covered includes everything from skilled home care, to occupational and physical therapy, to respite care to relieve stressed families.

The federal share of this program is capped, and the new funding is phased in over seven years. When fully implemented, we anticipate that this program will go far in addressing—approximately $38 billion per year—in the oft-cited "institutional bias" in federal long term care spending.

In addition, the Medicaid long-term care program will continue for low income children both institutional services, including ICFs/MR; and community-based services, including personal care, home health, and Medicaid home and community waivers.

OTHER INVESTMENTS FOR CHILDREN

The President recognizes that insurance alone can not meet the needs of our children. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals.

First, the Act includes two new grant programs to support school health education programs and to fund school health services. Under the Act, $50 million per year will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes $100 million per year rising to $400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and injuries and referral

and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

In addition, new funding will be authorized to help support public health initiatives of special importance to the health of children including immunizations, lead poisoning screenings, health education and violence prevention.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors including pediatricians, obstetricians and family physicians to ensure that children and expectant mothers will not lack appropriate medical care.

CONCLUSION

Mr. Chairman, the Health Security Act was designed to guarantee all Americans access to comprehensive medical care. In particular, the Act's investment in the health care and health security of our children is one of the best investments we can make in our future.

PREPARED STATEMENT OF BETTY A. LOWE

Mr. Chairman, members of the Committee, I am Betty Lowe, M.D., President of the American Academy of Pediatrics. I am here today representing our 47,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Thank you for inviting me to address the important issue of health care reform and its effect on children.

Children face many obstacles in the health care system, but one of the hardest to overcome is how most people view child health issues. They assume that in health care reform, what's good for adults is also good for children. The record suggests the contrary. The bedrock of the health care reform debate should be: as children go, so goes our country.

The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care, with an emphasis on prevention, is the single most important economic decision that will be made in the health care reform debate. As you write this legislation, specifically here in the Finance Committee, you face a choice: deal with these problems while children are young, or America will pay ten-fold down the road. Morally, economically, medically, keeping children well and preventing illness makes sense.

But if that's true, then why do children have to struggle to become integrated in the current health care system? Why are children with relatively minor problems, like ear infections, showing up in emergency rooms with chronic problems? Why should children with cancer or other serious diseases be at risk because their parents lose their insurance coverage? Why do young parents have trouble immunizing their children? I don't presume to know all the answers to these questions, but I do know these problems seriously effect children and their families.

Having a sick child is one of the toughest things parents have to deal with. Unfortunately, their anxiety is compounded by a health care system gone awry.

Families have to fight with insurance companies—because insurance companies are too often making decisions about what, when and by whom their children will get care. These families work with pediatricians who are being crushed by an avalanche of paperwork and regulation. The Academy applauds President Clinton, First Lady Hillary Rodham Clinton, and other Members of Congress who are working to put an end to this bureaucratic overkill, and enact comprehensive health care reform.

I know through your questions we will discuss the details of the various reform proposals, so let me turn for a moment to the Report Card on Health Care Reform for Children that was released a short while ago. While we realize that the health care reform debate is very fluid right now, we thought it would be helpful to provide Members of Congress with an independent snapshot of how children fare under various Senate health care reform plans. Although there are some significant and meaningful substantive improvements that need to be made, of all the health care reform plans currently under consideration, President Clinton's health care reform plan is the best for children. I hope that you will use this report as a measure for assuring that children don't get lost in the health care reform debate.

ACADEMY EFFORTS

The American Academy of Pediatrics has long been a proponent of health care reform focusing on the health care needs of our nation's children and youth. As you

know, of the approximately 37 million Americans who have no health insurance, 11.8 million children under the age of 21 are uninsured. Who are the uninsured? In 1991, 58% of uninsured children were dependents of full time, full year workers. In essence, they are the children of working class America. Many children are without adequate insurance coverage for necessary treatment services and for even the most basic care needed to prevent unnecessary disease and death. Still others are "uninsurable" because of preexisting, chronic or recurring conditions. For too long, children (and women) outside the labor force have been only incidental, indirect and insecure beneficiaries of health insurance. The objective should not be to simply insure against risks of unexpected costs, which is the premise of the insurance model today, but to provide for routine, preventive care as well. The record simply does not support the contention that if society takes care of adults, children will be cared for as well. We must not forget our nation's children in this debate.

S. 1456: "The Children and Pregnant Women Health Insurance Act of 1993"

To assure that the needs of children would not be lost in the health care reform debate, the Academy worked with Senator Chris Dodd (D–CT) in an effort to establish health care as a right for all children under age 21 and pregnant women. Senator Dodd introduced S. 1456, "The Children and Pregnant Women Health Insurance Act of 1993 on September 14, 1993." We commend Senator Dodd for his ongoing efforts to speak out for children in this debate. While we support comprehensive health care reform for all Americans, S. 1456 serves as our benchmark for children's health care, by which the American Academy of Pediatrics will evaluate all other health care reform proposals.

Let me also at this time, salute Chairman Riegle and this subcommittee for your determined efforts to focus the debate on children's needs.

The American Academy of Pediatrics' role in the coming months will be to ensure that children's needs are addressed in the health care reform debate. Toward that end, we need to develop a "child proof" proposal that will protect children's health care services. The Academy urges Congress to consider the following key issues:

COMPREHENSIVE BENEFIT PACKAGE

It is critical that health care reform include a mandated, comprehensive benefit package that emphasizes prevention and primary care, and spells out specific health benefits that address the unique health care needs of children. If they are not specifically defined up front, children may not get appropriate benefits, or even access. Without such a mandate, it becomes difficult, if not impossible, to guarantee coverage. Preventive care, the core of pediatric medicine, currently is poorly covered by many insurance companies, despite the cost-effectiveness and medical efficacy. The Academy believes that preventive care is critical to any proposal designed to provide a healthier future for our children. Benefits should meet the unique health care needs of children recognizing that children are not "little adults." To ensure that the benefit package continues to provide appropriate benefits for children, there needs to be adequate pediatric representation on all national and state boards created under health care reform. The fact is, whenever the standard benefit package is finally established, that is probably all that most children will get. While adults may purchase supplemental benefits, chances are that children will be left with whatever benefits they get from the standard benefit package.

Age appropriate schedule of benefits and services:

Also key to any continuous, comprehensive benefit package that addresses children's needs, is a timely schedule for the delivery of those benefits and services. A schedule has been developed by the Maternal and Child Health Bureau (MCH) of the U.S. Public Health Service and the Health Care Financing Administration (HCFA). The report, "The National Guidelines for Health Supervision of Infants, Children and Adolescents" or "Bright Futures," involved over 150 distinguished professionals representing child health and related perspectives, and is due out early next year. This report examined the issue of an appropriate schedule of visits for children in greater detail than any other report, including the much-quoted U.S. Preventive Services Task Force Report, which ironically, never studied this particular issue in depth.

The use of an age-appropriate schedule of visits for delivery of benefits and services to children is critical to achieve the greatest value for the benefits provided. Anticipatory guidance visits, for example, can play a key role in avoiding injuries and disease, and detecting child abuse and neglect. The earlier we get children in for visits, the better chance those children have for a healthy and productive future. **The Academy urges Congress to adopt the National Guidelines for Health Supervision of Infants, Children and Adolescents (Bright Futures Project)**

schedule of visits for delivery of benefits and services as the norm for children.

Children with chronic illnesses and other disabilities

Children with chronic illnesses and other disabilities as well as their families need access to a broad, multidisciplinary group of services, mainly community-based, that allow them to participate in all aspects of community life, especially school. Two to three million U.S. children under age 21 have significant and relatively severe long-term health conditions. Many require few long-term benefits beyond regular health care services. However, of this larger group, about 50,000 are assisted on a daily basis by major technologies, another 50,000 to 100,000 require other home and community services, and about 400,000 require limited non-physician services.

The President's plan holds important promise for children with disabilities, mainly through the assurance of universal access to basic health services. Plans for rehabilitation services, long term care benefits, mental and substance abuse services and organized systems of care, however, need to be clarified.

It appears that under the main acute care benefit plan, home health care and rehabilitation benefits (such as speech, occupational, and physical therapies) would be available only after hospitalization or injury. Most children with disabilities will survive to adulthood and with appropriate preventive and habilitative services can become functioning and productive adults. **We recommend that language be clarified to specifically include these children and that overly restrictive limitation be modified.**

Long-term care

The Long-Term Care (LTC) program within the Health Security Act is primarily designed for older adults. Adult standards for eligibility, with the exception of technology-dependent children under age six are used. LTC services should be available to all children through age 21, and standards for eligibility should be appropriate for children.

The current long-term care proposal has very narrow eligibility, requiring limitations in three or more activities of daily living or (for younger children) evidence that services are needed to prevent institutionalization. These limits virtually exclude children who need services. Furthermore, the plan allows a great deal of state variation in determining eligibility and services, even to the degree of excluding children. **We suggest broader eligibility criteria, specifically similar to those for determining eligibility for SSI disability payments for children. Furthermore, more specific program standards should be set to ensure appropriate programs for children and adolescents with severe disabilities in each state.**

Mental Health and Substance Abuse Treatment

It is extremely important to ensure that there are viable alternatives to inpatient hospitalization for children who need mental health services, so that they can remain with their families to the greatest extent possible. Intensive day treatment, for example, can be better for the patient therapeutically, *and* more cost-effective than hospital care in many cases. **We strongly urge that children promptly have access to the comprehensive mental health services they need without restrictive limits.**

Elimination of pre-existing condition exclusion clauses in insurance

Pre-existing condition exclusion clauses in insurance represent a serious and unnecessary barrier to care for uninsured children. Uninsurability due to pre-existing medical and mental illness conditions must be eliminated, and we commend the President for his determination to do that in his proposal.

Public Health

Only the MCH Block Grant contains funding targeted specifically for children with special health care needs. **Maintenance of funding support for the MCH Block Grant program during the transition to health reform should be adopted to ensure an explicit focus on MCH populations. In addition, funding for MCH population-based services (e.g., neonatal screening, poison control centers) should be identified and covered.**

There is a further need to support the infrastructure of care. Needed programs include regionalized systems of care for children with chronic illnesses, specialized programs for children with developmental disabilities, regionalized perinatal programs, and genetic screening and support programs. Health care reform measures should explicitly describe means to support access to these activities, along with

mechanisms to integrate these structures with the basic health plan. As the President has proposed, the plan also should provide funds for health promotion and disease prevention activities, including investigation of and control of adverse health conditions, such as cooperative activities to reduce violence in communities.

QUALITY

We must ensure that health care reform provides quality care for children. Quality care for children involves specific referral to pediatric specialties. We need to know, for example, that, in a life or death situation when a child with a heart problem is rushed to the emergency room, they will have access to a pediatric cardiologist. We need to ensure that all children who need emergency medical services will receive care from properly equipped and age-appropriate facilities and trained personnel.

Medical Home

The Academy encourages the medical home concept for health care reform, because it gets to the very heart of the issue of quality. A medical home is a regular and ongoing comprehensive source of health care, available around the clock, 365 days a year. It provides preventive care, early treatment of acute diseases and the coordination of care for those with chronic or disabling conditions. The Academy believes that for children and adolescents, this medical home is best provided by pediatricians.

One-tier system

The Academy believes that a one-tier system of health care must be established in this country. Regardless of initial safeguards, any public plan designed primarily for low-income people would eventually degenerate into a two-tiered system of care as the result of inevitable political and economic pressures. Our experience with Medicaid demonstrates this.

Medicaid has perpetuated a two-tiered system of care in which eligibility, benefits and reimbursement limited by lack of funds, vary from state to state. Medicaid still retains a welfare stigma and must be applied for with a means-test administered by the public aid system. Working class families struggling to stay independent find this aspect of the program distasteful and resist enrolling their children.

The Academy understands that under the President's proposal, parts of Medicaid will be rolled into the new system of alliances. While this is an important step in achieving a one-tier system of care, we must ensure that no child loses any benefits they currently have on Medicaid (including Medicaid's Early and Periodic Screening, Diagnosis and Treatment [EPSDT] services) either during the transition, or once they are in an alliance. Also, if health care reform limits the increase in Medicaid funding, we must ensure that children still receive adequate and appropriate funding for the health services they need.

WORKFORCE

Passage of health care reform may eliminate financial barriers to needed health care for many children and generate an increase in demand for primary care physicians. These children and adolescents will need quality health care, the provision of which can be complex and time consuming. Pediatricians are the most appropriate providers of primary care for infants, children and adolescents.

The Academy recommends

- The creation of an independent National Health Care Workforce Commission, insulated from the political process and with broad and balanced representation from the primary care community, including pediatrics, as well as the non-primary care community. Among the activities the Commission would be responsible for are: projecting the aggregate need of the medical care workforce for the delivery of health care; determining the necessary number of residency positions on a national basis, including international medical graduates; and allocating residency positions by specialty and subspecialty with regard to medical personnel and population needs;
- The costs of graduate medical education should be shared by all payers;
- Primary care residents should receive total compensation that is equal to or greater than other residency positions in the institution;
- Incentives should be encouraged, both short-term and long-term, for medical students, residents, and physicians (especially under-represented minority groups) to choose primary care.

Presently there is a national shortage and geographic maldistribution of pediatricians the effects of which could be acutely aggravated by health care reform. The Academy believes that there is a need for increased support for primary care specialties as a whole, and pediatrics in particular. To this end, we believe a short term strategy must be accompanied by long term incentives for medical students, residents, and physicians (especially under-represented minority groups) to choose primary care. A full array of support for primary care should be considered including: expansion of the National Health Services Corp; continuation and expansion of primary care training programs, such as Title VII; loan forgiveness in return for practicing in identified under-served areas; loan repayment based on a percentage of earnings; forbearance and deferment of low interest loans for entering primary care; development and implementation by all payers of a pediatric RBRVS and increased payment for pediatric services; increased funding for primary care research and other system-wide supports for pediatric and other primary care specialties including the reduction in administrative burden to primary care physicians.

COST CONTAINMENT

We recognize the importance of cost containment in any health care reform proposal. However, we must not compromise our children's health care. *With respect to children, specific cost-containment measures should include the following:*

- An emphasis on preventive care, as exemplified by the cost benefits of immunizations, as well as long term gains in early identification and amelioration of chronic disabilities;
- Targeted, income-adjusted cost-sharing;
- Delivery of health care services in appropriate sites, such as substituting costly emergency room services with primary care in an office setting and promoting the medical home concept of continuity of care, and;
- Coordination of care for children with special health care needs.

CONCLUSION

As pediatricians, our intention is to focus the Congress and the American public on the health care needs of children. To that end, as I mentioned earlier, the Academy has developed a Report Card on Health Care Reform for Children which offers a snapshot analysis of how we view the adequacy of various health care reform plans currently under Senate consideration. It is important to note that this chart is not exhaustive. We have, however, identified several issues important to children and families. Our Report Card makes clear that although there are some significant and meaningful substantive improvements that need to be made, of all the health care reform plans currently under consideration, President Clinton's health care reform plan is the best for children.

The categories included in our Report Card highlight key issues for children:

Guaranteed coverage is critical to ensuring that all children receive the coverage they are entitled to. Leaving such coverage optional will produce a health care system where there will be children still without the health care coverage they so desperately need.

A **comprehensive benefit package** must be spelled-out, up-front for children in the package, if we are to guarantee that they will receive benefits appropriate to their unique health care needs. The President's plan, along with S. 1456 and S. 491 specifically detail their benefit packages, rather then leaving such benefits to be "determined later" by a national board or some other entity.

The comprehensive benefit package should include **age-appropriate benefits,** where children get the care they need based on a timely schedule for the delivery of those benefits and services. **Children with special needs** must not be left out. It is important that appropriate coverage be provided to children not only after hospitalization or injury but for chronically ill children as well.

All of the proposals on our checklist address the issue of **insurance reform,** but not all of them produced a **one-class system of care** replacing Medicaid and guaranteeing that all children have access to a standard benefit package.

Promoting healthy lifestyles is critical for our nation's children, particularly adolescents. Issues such as smoking, drug abuse, and violence need to be addressed. The President's plan provides a number of important initiatives in this area, particularly authorizing funds for school health education programs, including planning grants for states and local education agencies.

Other issues such as **mental health, choice of provider, pediatric research, pediatric workforce** and the **role of the Public Health Service** are key ingredients to developing health care reform that meets the needs of our nation's children.

We are faced with a historic opportunity to reform our health care system. Providing all children and adolescents access to health care should be the foundation upon which meaningful health care reform will be built. Because health care reform for children is really about giving children a chance to reach their potential in life. If we can keep children well, they can have a fair shot at making the best of their lives, and that's all anybody can ask for. The 47,000 pediatricians at the American Academy of Pediatrics earnestly look forward to working with the President and this committee as health care reform moves through the legislative process.

Thank you.

PREPARED STATEMENT OF RANDALL L. O'DONNELL

Mr. Chairman, I am Randall L. O'Donnell, President and Chief Executive Officer of The Children's Mercy Hospital in Kansas City, Missouri. Children's Mercy is a regional pediatric medical center which offers comprehensive and specialized services to all children, regardless of race, religion, residence, or ability to pay. Our hospital is committed to education, research, and service as a child health advocate on local, state, and national levels.

Thank you for the opportunity to testify before you about children's health needs and health care reform on behalf of NACHRI, the National Association of Children's Hospitals and Related Institutions. I am a member of NACHRI's Board of Trustees and serve on its Council on Child Health Care Financial Requirements.

NACHRI represents more than 130 institutions in the United States and Canada, including: free-standing acute care children's hospitals such as my own, pediatric departments of major medical centers, and specialty children's hospitals devoted to specific services such as rehabilitative care for children.

Children's hospitals play an essential role in the delivery of care to the most vulnerable of children—the sickest, the poorest, and those with the most specialized care needs. For example, on average, children's hospitals devote nearly one-third of their beds to children in intensive care units, more than 44 percent of their inpatient care to children who depend on Medicaid, and more than 70 percent of their care to children with a chronic or congenital condition. Children's Mercy is representative. For example, it devotes 50 percent of its care to children assisted by Medicaid, and 40 percent of its beds to intensive care.

Children's hospitals are essential to children's access to both the basic and the specialized care they need today. They also are essential to children's access to care tomorrow, because they are devoted to training the next generation of pediatric health care professionals, and they are engaged in ground-breaking medical research for children. For example, children's hospitals and pediatric departments of major university medical centers represent only seven percent of all hospitals, but they train the majority of pediatricians and the vast majority of pediatric subspecialists.

Because of their missions of clinical care, education, and research devoted to children, children's hospitals bring two fundamental observations to the debate over national health care reform:

- First, children desperately need national comprehensive health care reform, because children are at the very frontlines of erosion in private health care coverage and change in the health care marketplace.
- Second, health care reform must be tailored to fit children's different health care needs, because when it comes to children's health care, one size won't fit all.

I would like to discuss each of these observations in more detail and then conclude my testimony with a discussion of our views on the major health care reform legislation pending before Congress.

CHILDREN NEED COMPREHENSIVE HEALTH CARE REFORM

Children desperately need comprehensive health care reform, because they are at the frontlines of the erosion in commercial health care coverage. Studies show that in the struggle to cope with rising health insurance costs, both employers and individuals often draw the line first at paying for dependent coverage. Loss of dependent coverage, coupled with pre-existing condition exclusions and life-time maximums on coverage, hits children hard, especially those requiring the care of a children's hospital.

As a consequence, more than one in three children in the United States now depends either on Medicaid, which is a critical but often underfinanced poverty program, or on charity to pay for their health care. That proportion continues to grow.

In other words, in 1992, 13.5 million children depended upon Medicaid and another 9.5 million children were uninsured, representing 35 percent of the nation's 65.1 million children, according to estimates based on U.S. Census Bureau data.

Medicaid has become the nation's safety net for children's access to health care—particularly children with special care needs. The emergence of Medicaid as the children's safety net has been a tremendously important development. The children's hospitals and the families they serve are deeply grateful to the members of this subcommittee, including its leaders, who fought for so many years to enable Medicaid to cover more and more children left without private insurance. But we know that Medicaid often has been challenged to fulfill its promise to children because of inadequate resources for eligibility, outreach, and payment. We also know that many states are now stretched to the financial limit by their Medicaid programs. In today's fiscal and political climate, Medicaid and charity are an imperfect and ultimately financially unsustainable safety net for children.

Children also are at the frontlines of change in the health care delivery market place, and the pace of that change is about to step up substantially because of Medicaid. In health care marketplaces around the country, we are seeing a significant new surge in the conversion of traditional indemnity coverage for fee-for-service health care into managed care coverage, including enrollment in risk bearing, capitated health plans.

Now, many state Medicaid programs are contemplating what the State of Tennessee has just received federal permission to do—enroll all Medicaid recipients into capitated managed care plans in a matter of only months. Since half of all Medicaid recipients are children, and 70 percent are mothers or children, the conversion of Medicaid fee-for-service to capitated managed care will be especially significant for children and their ability to receive the care they need. If done right, managed care holds great potential for children by creating incentives for them to receive the health services when they can benefit most from them. But make no mistake about it, the statewide Medicaid managed care experiments upon which states are embarking are experiments that affect primarily children.

That is why we believe health care reform is so important for children, both to give all children coverage of uniform health care benefits and to influence the way in which health care is financed so that universal coverage translates into access to appropriate care.

HEALTH CARE REFORM SHOULD BE TAILORED TO FIT CHILDREN'S NEEDS

Many members of this subcommittee have visited a children's hospital—as a parent, family member, or friend of a patient or as a guest of the hospital. You know that our institutions look and feel very different from other hospitals. You know that the care givers who work with our institutions often have different training and different experience than care givers in other hospitals have.

All of these differences that define the character of a children's hospital might be summed up by the slogan: "When it comes to children, one size won't fit all. We must tailor health care to fit their needs." This slogan may have a simplistic ring to it, but it has profound implications for the way we deliver care to children. Just this past summer, the Institute of Medicine issued a major report on emergency care for children that concluded our health care delivery system is failing to meet the needs of children who suffer from injury or trauma, because all too often our emergency and trauma care services are designed to fit the needs of adults or "average" people, not the needs of children.

For example, because children have smaller veins that often are not receptive to emergency injection of fluids, such injections may need to be made directly into their bone marrow. And because children's blood is smaller, injured children frequently experience a much faster drop in blood pressure. As a consequence of emergency services not being designed to fit these kinds of different needs, children's survival and recovery from injury or trauma can suffer.

The children's hospitals believe it is equally true that when it comes to health care reform, one size won't fit all. We must tailor the requirements of reform itself to fit children's needs. I would like to give you four examples of what I mean by focusing on four areas of consensus on health care reform between leaders in both political parties. These areas of consensus involve commitments to uniform benefits, managed care, cost containment, and Medicaid's replacement.

Uniform Benefits.—Leaders in both political parties have advocated that the federal government establish, by act of Congress or independent commission, a uniform benefit package for all Americans, with special emphasis on primary and preventive care. That is a very important, bipartisan commitment, which is sure to benefit children, for whom preventive and primary care often is the least expensive and prom-

ises the best financial returns in terms of well-being and future productivity. However, as experts in the care of children with special care needs, we know that it is equally important to focus attention on how the benefits will cover the needs of the child with a chronic or congenital condition, such as cerebral palsy.

For example, if standard benefits limit coverage for rehabilitation to treatment of "illness" or injury," they could be subject to the risk of interpretation that they do not cover congenital conditions, which are the result of neither illness nor injury. Or a limit on coverage to treatment that results in "improvement" of function could deny coverage of therapies that would enable children with special needs to "maintain" a level of function, allowing them to attend school or live at home. Or it could deny coverage of therapies prior to surgery that could be essential to a successful outcome. In addition, an "improvement" standard may not recognize the need for "habilitation" to help children attain function for the first time.

That is why children's hospitals say that the uniform benefits in health reform must be tailored to fit all children.

Managed Care.— Leaders in both political parties believe that in order to restructure the way in which we deliver care, we need to promote more enrollment of individuals and families into risk-bearing, capitated health plans. Whether they call it managed competition, managed collaboration, or something else, both Democratic and Republican leaders on health care reform believe we should give health plans an incentive to manage the care needs of individuals cost-effectively by giving them a single, fixed per capita payment—adjusted for the risk associated with the individual's health needs—for every individual enrolled.

Managed care has great promise to meet the needs of children if financial incentives facilitate their access to primary and preventive care. Indeed, through the provision of multi-disciplinary care involving the family, many children's hospitals have pioneered in managed care in the best sense of the word by trying to make sure the child receives the most appropriate care, including inpatient care, only when it is truly necessary.

But if managed care is purely cost-driven, it can have the opposite effect for children, denying them access to appropriate care instead of assuring it. The fact is that many of the protections essential to managed care—risk adjustment, public cost—reporting, measures of quality and outcomes—have not been developed for children. At the same time, because so few children comparatively require hospitalization, they are more dependent than adults on having access to regionalized centers of care. These are providers, both institution and individual, who see a large enough volume of pediatric patients with specialized conditions that they are able to achieve and maintain both expertise and efficiency in pediatric care.

Such institutions—children's hospitals—also carry the added costs of their commitments to serving a disproportionate share of low income patients, training the future generation of pediatric health care professionals, conducting pediatric medical research, and caring for the sickest of patients. If driven only by costs and lacking adequate tools for risk adjustment or measures of quality for children, managed care plans often will refer only the sickest and most expensive patients to children's hospitals and other pediatric specialized facilities, making them financially unsustainable. Or, to gain competitive advantage, managed care plans will seek to prevent children's hospitals from contracting with multiple plans, which often is essential for the hospital to serve a large enough population of children to sustain its specialized services. These are not concerns borne out of speculation; these are the real life experiences of children's hospitals seeking to fulfill their missions in managed care driven markets today.

That is why children's hospitals believe it is so important that health care reform built upon capitated managed care must manage the competitive market to ensure children's access to the care they need. It is important to ensure that health plans:

- provide access to pediatric specialists and subspecialists, so that when a child needs a cardiologist or pulmonolgist or other subspecialist, it is one who is trained in pediatric cardiology or pediatric pulmonology;
- allow pediatric providers to contract with multiple plans;
- avoid unnecessary duplication of regionalized services;
- contract with and refer patients to hospitals that have demonstrated themselves to be "essential" to the children of low income and medically underserved communities;
- contract with and refer patients to academic health centers and other providers specialized in the treatment of rare and unusual conditions, including pediatric specialized providers;
- separate the financing of graduate medical education from patient care reimbursement; and

- require health plans, in accounting to the public for the costs and quality of care, consumer satisfaction, and health status of the population served, to report in terms that are specific to children and their needs.

Cost Containment.—There has been much disagreement both between Democrats and Republicans, and within their respective parties, about whether and how to cap the growth in health care spending nationwide, the growth in commercial insurance premiums, or the amount of reimbursement given to individual providers.

However, as institutions that devote a major portion of care to children assisted by Medicaid, children's hospitals are struck by the fact that leaders in both political parties strongly agree on capping the growth in Medicaid, at least at a per capita level. That is the equivalent of a *de facto* spending cap on health care spending for children. Therefore, even if they may not support the principle of government caps on health care spending, children's hospitals already live with the reality of caps on Medicaid. We believe it is imperative to talk about the need for cost containment strategies to be adjusted to fit children's needs.

Let me explain why this is so important. Children have different health care resource requirements than adults have, and the patients of children's hospitals have different resource requirements than children receiving care in general hospitals. For every hour in the hospital, a child on average requires 31 percent more routine nursing care than an adult; a child younger than two requires 45 percent more care than an adult. The patients of children's hospitals require even more intensive care, because they are younger, sicker, and more likely to have a chronic or congenital condition than the pediatric patients of general hospitals. Since nursing care is a major portion of the expense of hospitalization, these differences can have significant implications for the resource requirements of children.

Too often, strategies to cap health care spending fail to take into account these differences. We see proposals to cap national health care spending based on an extrapolation of historical rates of health care expenditures, in which the costs of children's and adults' care have been averaged together. In addition, children have been disadvantaged in historical spending—because they have been disproportionately poor, dependent upon Medicaid which has inadequately reimbursed care, and dependent upon primary and preventive care, which indemnity plans traditionally did not cover. Caps on health care spending will not make sense for children if they are based on historical spending, instead of an assessment of children's real health care needs.

Most advocates of capitated payment for health care have recognized the importance of risk adjustment—adjustment of capitation for the risk of higher or lower costs of care associated with an individual. Without such risk adjustment, a health plan or health care provider who cares for a population that is disproportionately sicker would be at financial risk. This is exactly what a children's hospital is—an institution which specializes in caring for higher risk children with the most complex care needs. However, experts in capitation and risk adjustment have testified before Congress that risk adjustments specific to the needs of children—particularly children with special care needs—simply do not exist, and will take years to develop. That is why children's hospitals believe we must begin now to invest in risk adjusters for children, even before embarking on health care reform. And if reform is implemented before pediatric risk adjusters are developed, interim measures, such as mandatory reinsurance for a wide range of children's chronic and congenital conditions or exclusion of these cases from capitation, will be necessary.

Children's hospitals have learned the necessity of adjusting cost containment strategies to children's needs through years of living with state Medicaid programs and private payers, which have adopted the Medicare diagnosis related groups (DRG) payment methodology, even though it was not designed for a pediatric population. According to financial experts whom the federal government often has used for payment policy analysis, no children's hospital could survive financially if it were subject to the Medicare payment system unadjusted for the needs of children in general and the needs of children's hospitals' patients in particular.

That is why children's hospitals believe that in health care reform, cost containment strategies must be tailored to fit children's needs.

Medicaid.—According to opinion surveys, most people think Medicaid is either a welfare program or Medicare. But to children's hospitals, Medicaid represents the nation's largest and most important child health program. No single program, public or private, affects more children nationwide or more children in children's hospitals. Therefore, it is especially important that great care be given to how health care reform transforms Medicaid.

Let me give you an example. Many leaders in both political parties have called for the elimination of Medicaid disproportionate share payment adjustments—extra

payments given to hospitals that serve a disproportionate share of low income patients. They contend that such disproportionate share payments are only needed to pay for the costs of care of charity patients. With the achievement of universal coverage, they believe, such payments no longer will be necessary.

However, to children's hospitals, disproportionate share payments represent something entirely different. In most states, including Missouri, the Medicaid program makes disproportionate share payment adjustments because the base Medicaid rate is substantially inadequate to cover the costs of care. These payment adjustments have been critical to the ability of children's hospitals to play such an important role in providing access to care for children of low income families.

If Medicaid financing continues at historically inadequate levels, exacerbated by the elimination of disproportionate share payments, health plans and communities with larger numbers of low income people will be particularly hard hit, as will the institutions devoted to serving them. This will be doubly true for institutions such as children's hospitals, which serve large numbers of both low income and high risk patients.

That is why children's hospitals say that Medicaid's replacement in health care reform needs to be tailored to fit children's needs.

NACHRI'S COMMENTS ON HEALTH CARE REFORM PROPOSALS

Over the last many years, the Finance Committee and especially many on this subcommittee have worked as hard as anyone in Congress to strengthen Medicaid so that it could become a true safety net for children and to move the Congress toward the achievement of national health care reform. The children's hospitals and the children and families we serve are deeply in your debt.

We also recognize that despite the valiant efforts of many, no one political leader has done more than President Clinton to move comprehensive health care reform to the top of the nation's political agenda. We strongly support his leadership, and we strongly support many of the principles we believe are fundamental to his health care reform initiative: universal coverage, comprehensive benefits, employer-based coverage, assurance of choice among health plans, recognition of the roles of essential providers of care to low income patients and academic health centers treating rare conditions, separating the financing of graduate medical education from patient care reimbursement, sustaining Medicaid eligible children's access to medically necessary care, and more.

A number of other important proposals, including ones sponsored by members of this committee, also address these basic principles. But for several reasons, NACHRI has thus far not endorsed in detail any individual legislative proposal. For one thing, the legislative language on all of the proposals still is only just becoming available. For another, as the committee members well appreciate, these proposals are enormous in their scope and implications for health care delivery, requiring much review just to begin to understand them, much less endorse them. For a third, we believe many of the proposals on the table could benefit from learning from one another. We believe the President's plan is a good place from which to build a coalition for health care reform, both in terms of his fundamental commitments and in terms of his willingness to consider changes in the details.

But most fundamentally, children's hospitals believe that we need to balance continually our commitment to advocating for comprehensive reform with our commitment to making sure that all children have access to the kinds of services they specifically need. Our institutions and the care givers we house have devoted professional and personal lifetimes to the details of children's health care needs. It has become a cliche in health care reform to say that the "devil is in the details," but it is nonetheless an absolute necessity in children's health care—whether it involves making a diagnosis, prescribing a treatment, or assessing health care reform.

Children's hospitals welcome the opportunity to work with the Senators of this subcommittee to advance health care reform for all Americans and to make sure it fits the needs of all Americans, including our children.

Thank you for the opportunity to testify today. I would be pleased to try to answer any questions you may have.

REPORT CARD ON HEALTH CARE REFORM FOR CHILDREN

	BREAUX	CHAFEE	CLINTON	GRAMM	WELLSTONE
Guarantees Coverage		✓+	✓+		✓+
Comprehensive Benefit Package	?	?	✓+		✓+
Strong Role for Public Health	✓		✓+		✓
One-Tier System			✓+		✓+
Insurance Market Reform(s)	✓+	✓+	✓+	✓	✓+
Pediatric Research			✓+		
Promotes Healthy Lifestyles	✓		✓+		✓
Age Appropriate Benefits	?	?	✓		✓
Children with Special Needs	?	?	✓		✓+
Mental Health	?	?	✓		✓+
Choice of Provider	?	?	✓+		✓+
Expands Pediatric Workforce	✓+	✓+	✓+		✓+

KEY:

✓+ = Good ✓ = Makes an effort ? = Incomplete Blank = Same as or no better than the current system

Developed by the American Academy of Pediatrics
November 16, 1993

PREPARED STATEMENT OF IRWIN REDLINER

Good morning and thank you for the opportunity to testify before this Committee.

I am Dr. Irwin Redlener, Director of Community Pediatrics at the Albert Einstein College of Medicine and Montefiore Medical Center in New York City. I am also President of the Children's Health Fund, a foundation which supports mobile and other special health care programs for severely disadvantaged children in a variety of locations throughout the United States.

Although we support pediatric health care programs in communities as diverse as the delta region of Mississippi and rural West Virginia on the one hand, we also support inner city projects in south central Los Angeles, Newark and the nation's largest health care programs for homeless children in New York City.

What we find among our various child populations who are very disadvantaged, who are often very isolated and almost always living within federally designated **Health Provider Shortage Areas** are common denominators which I will review since they are germane, in a fundamental way, to important principles of **health care reform.**

The most important point is this: our patients, mostly infants and young children, have either **no access** to care, or - as is usually the case- **access to inappropriate kinds of care at inappropriate times** and in **inappropriate places.**

We believe that, nationally, because of shortages or maldistribution of primary care doctors and other providers combined with lack of insurance coverage, there are at least 12 to 15 million children who are currently not getting the health care they should. It is probable, for example, that some 40% or 320,000 of the 800,000 poor and near poor children in New York City do not have functional access to appropriate levels of pediatric care.

These children are, in a sense, medically homeless.

Here is what this means:

1. Many poor children, while they can get to emergency care if extremely ill, they can't get the on-going, comprehensive, continuity oriented, prevention-focused, office-based care of the type that is considered standard fare for middle class, economically advantaged children. So poor children, children who are medically isolated, get **emergency care as a replacement for comprehensive care.** But emergency care is absurdly expensive and often comes too late to provide prevention of illness complications or hospital admission.

2. The other kind of care the twelve million plus medically homeless children get is episodic or categorical. They may get screening tests and lead programs; they occasionally get checked for TB exposure and they may get school entry examinations. They can get vaccinated in shopping centers and get rounded up during community-based immunization drives. All of this is a poor substitute for coordinated, comprehensive care in a place where the child is known, where records are kept and where follow-up is ensured.

3. Children who get their health care in the fits and starts of emergency rooms and one-shot initiatives are not getting what they need. As a result,

- immunization rates are below 40% for two-year-olds in many inner city neighborhoods and isolated rural communities;

- acute problems, like asthma or simple ear infections, can turn into chronic health problems which may interfere with learning and social function;

——— - there is no constancy of health provider to identify and manage certain problems which need intensive management and coordination. In my own NY program, by the time we see homeless children in our primary care medical home setting, they have a huge backlog of medical conditions which require a specialist or special service. In fact, nearly 1,000 specialty appointments are made annually for the 4500 or so children seen in our general pediatric program - a rate some four times that seen in the typical mainstream pediatric practice.

I am reviewing all of this to give you a sense of what we are dealing with as the nation faces, finally, the prospect of universal coverage. And none too soon.

Our children desperately need us to adopt the concept of universal access as soon as possible. More than any other aspect of reform, universal access must be on a "fast-track".

I am convinced that the President's National Health Security Act offers an extraordinary opportunity -more than any other approach currently on the table- to do what needs to get done for children. However, I urge you to pay particular attention to the following as the deliberations around health reform proceed:

1. No more than one-half of medically homeless children will achieve access to appropriate care by national health insurance coverage alone. The others will require intensive programs to examine and overcome the <u>non-fiscal</u> barriers from logistic concerns to lack of health providers and resources. This is why the enhancement and reorganization of the public health infrastructure, the funds to support enabling services and the defining and support of essential community providers is so important.

2. The benefit package as described in the President's plan is very good for children, but clearly not excessive. The message here is that nothing in the package should be considered available for negotiating away.

3. We must be alert to what the final product of reform is for children. Access to disparate programs, emergency care or assistance for catastrophic medical problems alone is not adequate. As pointed out earlier, children need a comprehensive, continuity-based relationship with a quality provider, what I referred to as a medical home.

Proposals that offer less than this for all children should be rejected. Here's are four questions which could be used to test the appropriateness of health reform proposals from the perspective of the nation's children:

1. Does it offer a fast-track universal access?

2. Does access incorporate fiscal and non-fiscal issues, including the enabling and public health infrastructure enhancements to make functional access a reality?

3. Does the proposed system encourage coordinated team-work among primary care providers, specialists, special services and support services?

4. Does the plan ensure significant preventive health initiatives as part of an explicit and detailed benefits package?

The President's plan offers strong and positive answers to all of these questions. As a child advocate and pediatrician, and even as a former single-payer, Canadian style health reformist, I do not see the other proposals currently on the table any where near as able to meet the health needs of our country's children.

Thank you.

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PREPARED STATEMENT OF CAROL REGAN

Good morning, Mr. Chairman and members of the Subcommittee. On behalf of the Children's Defense Fund, I'd like to thank you for holding this hearing on child health issues in health reform. Good maternal and child health care, as you know so well, is essential if this country is to ensure every child a healthy start in life. As you begin to consider the President's health care plan, which we have endorsed, and consider bills sponsored by others on the Finance Committee, it is imperative that special attention will be paid to the health and medical needs of children and pregnant women.

I want to thank Senator Riegle for his leadership this past year in passing the new immunization plan and for his commitment to assuring every child preventive health care. We hope that we can look back a year from now and thank the chairman and Congress again for passing a national health plan that includes not only immunization but a wide range of preventive services for children as well as the range of acute, tertiary and long term care services every family in America needs.

Every year the Children's Defense Fund compiles and analyzes data on children's health, from access to prenatal care and insurance coverage to vital statistics such as infant mortality, low birthweight, and immunization rates. And every year for nearly two decades we have pointed to some of the same simple solutions, solutions every other industrialized country knows to be true—that prevention and early intervention save money and lives and that the only way to truly hold down costs is to guarantee universal coverage. Children who fail to get a healthy start in life suffer health, education, economic and other consequences long after, and it is often too late or too expensive to remedy those consequences. Finally we are beginning to realize that we can't afford *not* to change course.

Small but significant gains over the past several years to expand Medicaid coverage for poor children have been unable to keep up with the rising numbers of uninsured Americans and out-of-control systemwide costs. We have more than eight million children and half a million pregnant women without any health insurance. Medicaid expansions, high risk pools, "barebones" insurance plans, small market reforms, hospital ratesetting—none have succeeded in covering all Americans or in holding down costs, and it is time now for systemwide change. We urge you to pass legislation that is universal for all Americans, not voluntary and less than universal; that is built on an employer mandate; that provides comprehensive, not barebones coverage; that is affordable and limits out-of-pocket costs, particularly for the poorest families; and that brings more clinics and health professionals into medically underserved communities where more than 20 million children live today. We believe these are the most fundamental principles of health reform for children.

The first principle—universality—is the guarantee that every American is assured coverage, at all times, and that no insurance company or employer is able to discontinue an individual's or family's coverage. The way to achieve this is to require that everyone participate in the system and that all employers pay a substantial share of the cost. The President's plan, S. 1757/H.R. 3600, guarantees that all citizens would be covered by January 1997, requires full participation of every citizen and every employer, and recognizes that anything less could leave millions uninsured as they are today.

Neither the bill sponsored by Senator Breaux (S. 1579) nor Senator Chafee (S. 1770) provides that same guarantee. While the Chafee plan includes a mandate, it is on individuals not on businesses, with public subsidies for low income families to help them purchase insurance. The proposal phases in the program by the year 2000, subject to savings in federal health spending. While this has the potential to provide universal coverage, it also could prompt employers who now provide insurance to drop it, resulting in tremendous dislocation, particularly for children as dependents, and great hardship for families.

S. 1579 offers no provision for universal coverage and instead relies on market and insurance reforms to encourage employers to offer coverage for employees to buy. Further, this bill proposes repealing Medicaid and setting up pools through which low income families will purchase coverage (with subsidies based on income). This perpetuates a separate insurance system for the poorest Americans; any real reform of our health care system ought to strive to put an end to such separate systems. Without integrating Medicaid beneficiaries into the mainstream insurance system, the poor—a disproportionate number of whom are children—will continue to get second-rate care.

The second fundamental principle of reform is that children must receive a comprehensive package of benefits which meet their diverse health and medical needs. Design of a benefit package also must take into account the unique needs of low-income children, whose health problems are compounded by poor health status asso-

ciated with poverty and whose families do not have the resources to get their children care outside of the insurance package. One in five American children is poor, and the numbers are higher for Black and Latino children (46.6% and 39.9% respectively). Congress recognized the special needs of poor children under Medicaid's benefit package—EPSDT—which, as you know, covers the full range of benefits a child would get in most good private insurance packages as well as services such as case management, rehabilitation, and screenings which have proved critical for children with developmental, physical or emotional problems.

Neither the S. 1770 (Chafee) nor S. 1579 (Breaux) fully define the benefits families would receive. Each requires that insurance plans cover preventive services, which we fully support, and prescriptions, eyeglasses, hearing aids and other services commonly provided in state Medicaid plans (if approved by a federal board) to individuals below poverty. Yet without a common and comprehensive set of benefits which all Americans have, we face the continuation of cost shifting and major gaps in coverage for the poorest and sickest individuals.

The standard benefit package in the President's bill emphasizes primary and preventive care and is comparable to or better than what most private insurance plans offer. The President's plan also provides additional, or "wrap-around" benefits to Medicaid beneficiaries, such as hearing aids and rehabilitation services, which are not included in the standard benefit package. We would urge the Committee to enact a common, comprehensive package of benefits, defined by law and not subject to a Commission; to reject attempts to scale down the basic package; and to provide children the most comprehensive set of benefits possible (with a residual wrap-around for poor and near-poor children if the universal package is not comprehensive). There is a growing consensus that prevention services are cost-effective and important to include, but for a child in need of a hearing aid, or a child with cystic fibrosis in need of respiratory therapy, these services are just as critical and could in fact be cost effective as well.

A third principle for reform is that access to care must be affordable and funding for premium and cost-sharing subsidies must be adequate and stable. It is essential that premiums and co-payments, particularly for low-income families, be kept very low in any health reform the Congress adopts. Since all the plans under consideration contemplate coverage through private insurance, they are all financed for the most part through flat (or capitated) premium payments. A mandate on an individual to participate in a system that requires the same premium payment for a minimum wage worker as someone earing, for example, $75,000 per year must be accompanied by some form of subsidy.

In addition, insurance plans with high cost sharing have and will continue to prevent low-income families from getting medical care. A recent Office of Technology Assessment background report titled "Benefit Design: Patient Cost Sharing" stated that ". . . *Congress should be cautious about the extent to which cost-sharing is relied on to control costs, especially for sick, low-income individuals. These individuals are the most likely to benefit from receiving health care services at no out-of-pocket cost and the most likely to be harmed by patient cost-sharing requirements.*" We urge the committee to consider nominal fees, similar to those under the Medicaid program, for low-income families.

We applaud each plan in its recognition of the need to assist low income families with the cost of insurance coverage. S. 1759 subsidizes premiums for those people below the poverty level and provides sliding scale subsidies for those between 100% and 200% of poverty. Senator Chafee's bill starts with subsidies only for those at 90% of poverty; those under 240% of poverty will eventually receive subsidies, but only as caps on the growth in Medicaid and Medicare provide the savings needed to fund those subsidies.

The President's plan subsidizes premiums for those below 150% of poverty and limits out-of-pocket cost-sharing for families on cash assistance (AFDC and SSI recipients) to $2 per doctor visit and $1 per prescription in the low cost plan, as opposed to $10 and $5 respectively for all others in the low cost plan. We are pleased that this has been included in the Administration's bill, but urge the Committee to extend such relief to other low-income families—poor and near-poor—as well. A family making the minimum wage is in just as bad a position to pay $10 per doctor visit as is a person on AFDC or SSI. Families will forego necessary care if co-payments stay this high.

A typical family of four (consisting of two parents and two children under 5) with a full-time minimum wage worker earing $8,500 per year would pay an average of $265 in co-payments for doctor visits and prescription drugs (based on utilization information from two national surveys) at the $10 per doctor visit and $5 per prescription co-payment level. These co-payment estimates are based on average utilization rates, so families with children with chronic health conditions, for example,

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will experience significantly higher co-payment obligations. When premiums and out-of-pocket costs for excluded services are counted, these costs will be prohibitive for many families. Health security for all low-income families will require co-payment protections similar to those for cash assistance Medicaid beneficiaries.

Assuring that low-income people actually receive the services they need—both through health plans and additional services provided through safety-net providers—is a fourth fundamental element which must be part of health care reform. The experience of Medicaid beneficiaries in managed care has been, at best, a mixed one. Safeguards and standards are especially necessary because low-income women and children typically will have access only to lower-cost plans, since they will not be able to afford the premiums and cost-sharing requirements of higher-cost sharing plans. The lower-cost plans have the potential of becoming overwhelmingly "poor people's plans" in some localities. Tough guidelines must be put in place to guarantee that marketing approaches of health plans, geographic territory covered by health plans, and links between health plans and essential community providers funded through the Public Health Service Act work toward mainstreaming low-income people in the health care delivery system. Health care plans will have to be monitored, and certain protections will have to be in place, to address incentives that plans may have to control utilization at the expense of access to necessary care.

Finally, let me mention a few additional issues relating to special populations of children. Many children and adolescents in the foster care system receive health care services through the Medicaid program. These children will continue to require the Medicaid scope of benefits and they will need special attention, since they get moved around so much, in order to assure that their coverage is portable and their access to health services is continuous. Similarly, the many children who live with one parent, or with non-parental relatives, or with non-relatives in informal settings will also require enrollment and portability protections that guarantee that where they live, who they live with and who is paying their premiums will not pose barriers to access to the health care they need. We look forward to working with the Committee to accomplish these goals.

After reviewing a number of bills under consideration in Congress, we have endorsed the President's bill since it includes the fundamentals essential to assure health security to all Americans. We know that this Committee will also work to achieve the goal of providing universal, comprehensive and affordable coverage for children and their families. We look forward to providing any assistance we possibly can as you work on legislation. The health of millions of children depends on this Committee and the decisions you will make over the next several months.

Thank you.

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ISBN 0-16-044430-6